NOVEMBER 15, 1949

MODERN MEDICINE

The Journal of Diagnosis and Treatment

Papillary Adenocarcinoma of the Kidney *(see page 57)*

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Dr. W. Calhoun Stirling and Col. J. E. Ash *(see page 8)*

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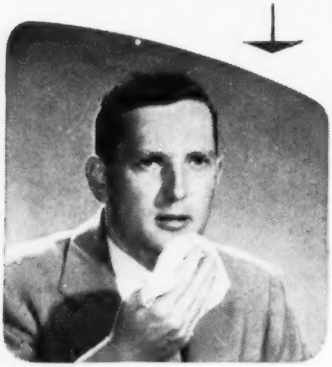

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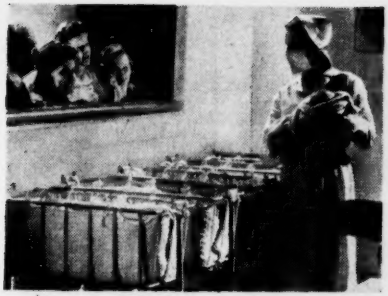

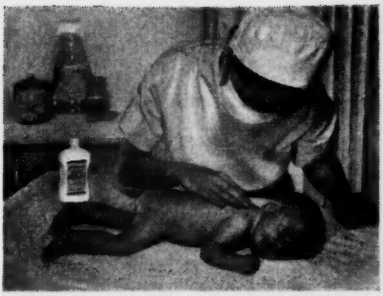

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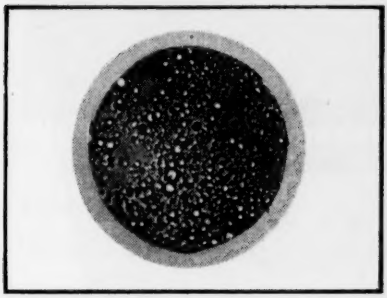

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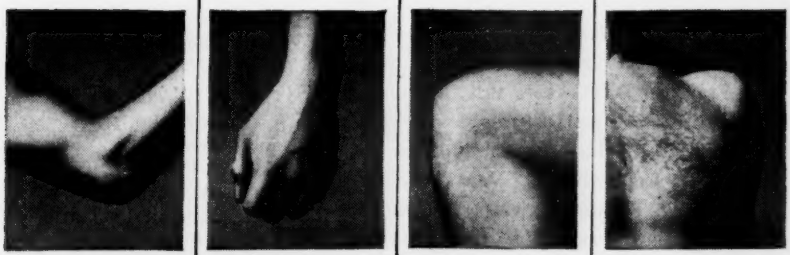

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MODERN MEDICINE

THE JOURNAL OF DIAGNOSIS AND TREATMENT

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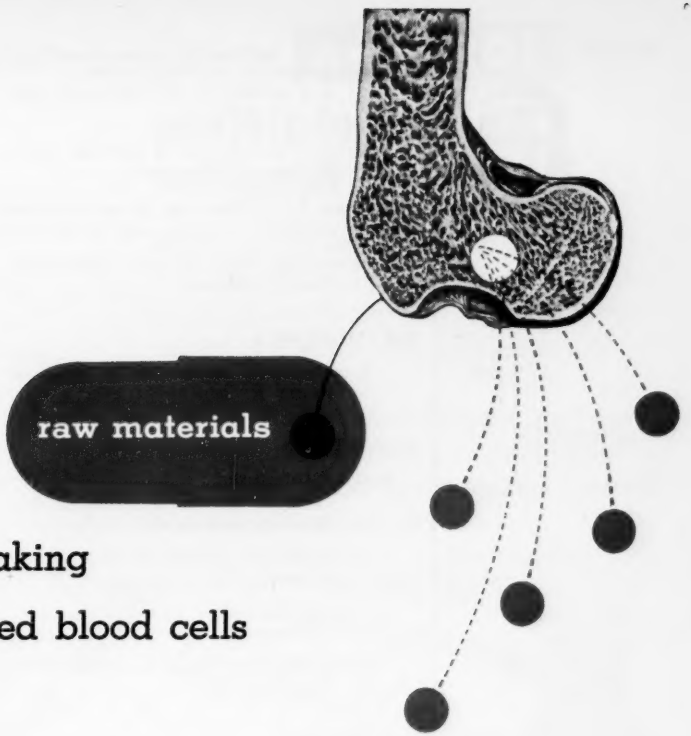
Contents for November 15 1949

VOL. 17, NO. 22

THE MEN ON THE COVER are W. Calhoun Stirling, M.D., Washington, D.C., of MODERN MEDICINE Editorial Board, and Col. J. E. Ash, M.C., U.S.A., retired, long-time director of the Army Institute of Pathology, Washington, D.C. Dr. Stirling, an international authority on genitourinary surgery, and Col. Ash, a preeminent pathologist, collaborated on the Special Article, "Papillary Adenocarcinoma of the Kidney" which starts on page 57.



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Contents for November 15 1949

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LETTER FROM THE EDITOR

Dear Reader:

The other day we received a note from a doctor who wrote:

I would like to know how it is that I have been receiving copies of your publication. I do not recall having subscribed for it, but would surely do so if you will advise me of my renewal date. Please let me know if I owe you anything.

Perhaps you, too, have wondered about the same thing. The answer is simple.

We endeavor to send MODERN MEDICINE to every practicing physician in the United States. Our function is to perform a selective reading service for all physicians and to report the developments in medicine that are of interest to a much wider group of practitioners than the regional and specialty journals can hope to reach. To make this service effective and a real contribution to the practice of medicine it should reach as many physicians as possible. Most medical journals are distributed through subscription. This is perfectly proper, for they appeal to a limited group. However, circulation by subscription is expensive to maintain and must always fall short of complete coverage. At the start of publication seventeen years ago, MODERN MEDICINE decided to forego revenue from subscriptions in the interest of reaching the greatest number of doctors. The record of the years testifies to the wisdom of this decision.

But the journal is free only in the sense that the reader does not have to pay for it. Editorial talent, slick paper, engravings, printing, and postage cost money. This money comes from the sale of advertising. Most journals derive their income from the sale of advertising *and* subscriptions. MODERN MEDICINE's comes from the advertisers alone. Not from a few, but from many. Thus the advertisers, hundreds of them, foot the bill.

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Correspondence

Communications from the readers of MODERN MEDICINE *are always welcome. Address communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Sunburn Protection

TO THE EDITORS: I find your magazine very valuable and a timesaver. Recently I've been going through some old copies and in the Oct. 1, 1948 number in the "Short Reports" I find an item about two compounds advocated by Drs. W. D. Kumler and T. C. Daniels for protection against sunburn (p. 92). I believe the reference was inadvertently omitted. Or if the work hadn't been published, do you know whether it has since appeared in print in more detail than you gave? I want to find out whether the products are on the market and if so under what name.

On a few other occasions the source of your material has not been stated. This is my only adverse criticism.

STELLA SIKKEMA, M.D.

Boulder, Colo.

¶The compounds used by Drs. Kumler and Daniels (ethyl-p-diethylaminobenzoate and methyl-p-dimethylaminobenzoate) are not yet commercially available. As to Dr. Sikkema's criticism, sources are always given if the work has been previously published.—Ed.

Read by Nurse, Too

TO THE EDITORS: May I tell you how much my nurse and I enjoy your magazine.

BEN EINHORN, M.D.

Los Angeles

Insulin and Obese Diabetics

TO THE EDITORS: In your Medical Forum section recently there appeared a comment from Dr. Arthur R. Colwell on the insulins and diabetes (July 1, 1949, p. 73). This article referred to the Symposium on Diabetes which appeared in your June 1 issue and which, incidentally, was quite complete.

Dr. Colwell lists obese individuals under the caption of those who should have protamine zinc insulin. With this listing I must take issue. This subject has been discussed with Dr. Colwell and I know that he does not intend to convey the meaning which is conveyed. It is difficult to recall any severe obese diabetics in my twenty-five years of seeing patients.

I am sure he does not refer to the older individuals because he has another group so designated. Furthermore, under the caption of globin insulin and protamine insulin mixtures, he lists young individuals. One is more or less forced to the conclusion, therefore, that obese diabetics should be given protamine zinc insulin.

While I am sure Dr. Colwell will insist upon weight reduction, I think more emphasis should be placed upon the state of obesity, particularly in the older or middle-aged patients who

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have a disturbance in sugar metabolism. Certainly these people should be made to reduce before insulin is given to them. It has been my experience, and I am sure it is shared by many others, that when such individuals are made to reduce they do not require insulin at all. In short, I think the medical profession should be more alert to the subject of obesity, certainly as it concerns the diabetic or potential diabetic.

I feel that to one who is not too well acquainted with the management of diabetes this comment might be misleading in the treatment of diabetes.

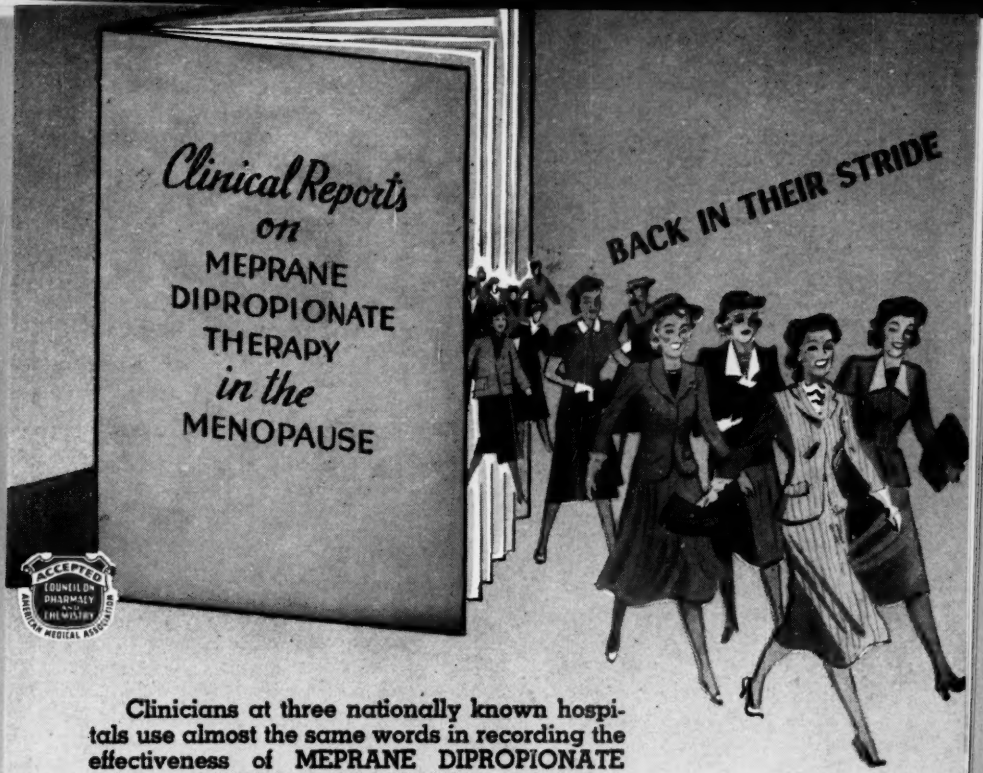
J. SHIRLEY SWEENEY, M.D.
Gainesville, Tex.

¶We sent Dr. Sweeney's letter to Dr. Colwell for comment. His reply follows. —Ed.

► TO THE EDITORS: Dr. Sweeney is correct in assuming that my summary of the indications for protamine insulin was not intended to imply that obese diabetics should necessarily be given that insulin. The incident emphasizes the inadequacy of a summary.

What I intended to say was that when a diabetic patient requires insulin at all, the one who is obese is more likely to have a mild form of the disease which is easily controlled with small doses of protamine insulin, in contrast to the one with diabetes so severe that he is thin and requires an insulin with intermediate action such as globin insulin or one of the protamine mixtures.

I also agree with Dr. Sweeney that obese diabetics should be urged to reduce, although I would not withhold insulin from them while they are reducing if it is necessary to control their sugar metabolism. The in-



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Bibliography

1. Sturgis, S. H.: Am. J. Obst. & Gyn. 53:678, April 1947.

2. Coulton, D. and Sewall, C. W.: Am. J. Obst. & Gyn. 56:541-548, Sept. 1948.

3. Lin, H. A. C.: Am. J. Obst. & Gyn. 54:296, August 1947.

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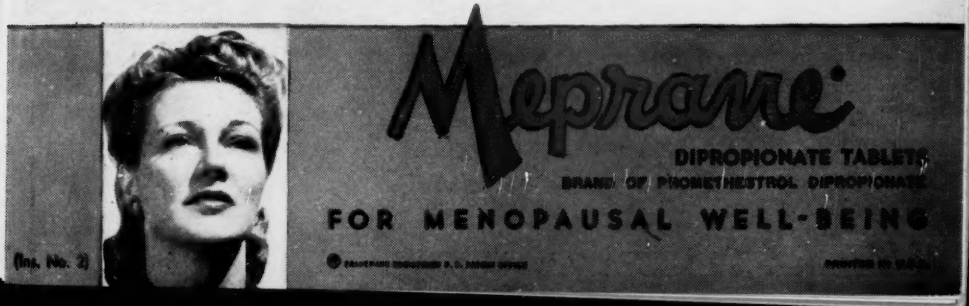

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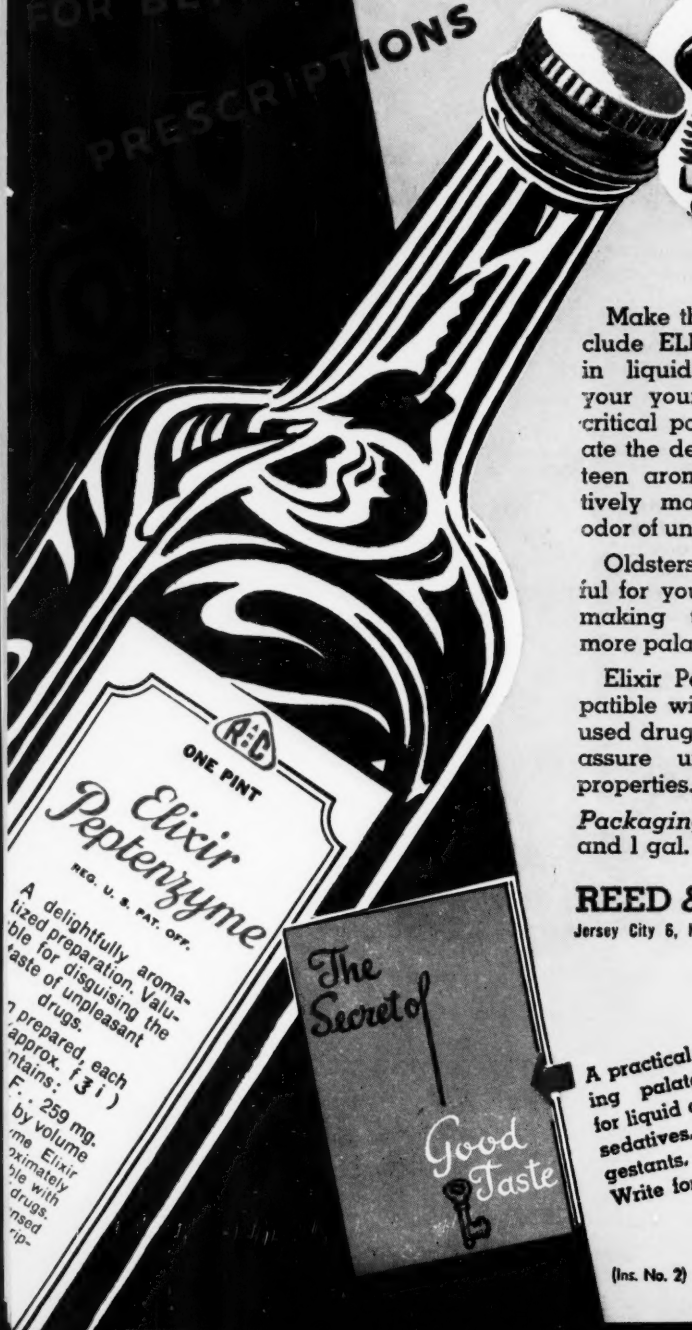

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sulin can always be stopped after weight reduction if it is then unnecessary.

ARTHUR R. COLWELL, M.D.
Evanston, Ill.

About That Diagnostix Collection

TO THE EDITORS: Kindly reserve my copy of the 1949 series of 24 Diagnostix. Thank you in advance.

FELIX OTTAVIANO, M.D.
Oneida, N.Y.

► TO THE EDITORS: Please reserve my copy of Diagnostix Collection. Thank you for your cooperation.

MAXWELL J. ANTELL, M.D.
Bridgeport, Conn.

¶To Drs. Ottaviano and Antell, and to all other readers who obtained the impression that the Diagnostix Collection was to be a separate volume, our apologies. The reason for the misunderstanding was the following notice which appeared on page 88 of the September 15th issue

> DIAGNOSTIX COLLECTION
>
> The 1949 series of 24 Diagnostix will be included in the MODERN MEDICINE ANNUAL—1950. Reserve your copy now.

What we meant to say in the last sentence of the notice was "**Reserve your copy of the MODERN MEDICINE ANNUAL —1950 now.**" The Diagnostix Collection is a part of the ANNUAL and is not available separately.—Ed.

Helpful Hints

TO THE EDITORS: I enjoy your magazine and feel it has many helpful hints.

SAMUEL CISSEL, M.D.
York, Pa.

"Hello, Mr. Smith. How's the eczema today?"

Mixup Straightened Out

TO THE EDITORS: I would like to call your attention to an error in the heading of the article in regard to auricular fibrillation in a normal heart that appeared in the September 15 issue of *Modern Medicine*, p. 47. The article is from the Lahey Clinic in Boston and not from the Mayo Clinic in Rochester, Minn. Dr. Hugh Hanson is now a fellow at the Mayo Clinic, but the report was written while he was a fellow at this institution.

DAVID I. RUTLEDGE, M.D.
Boston

► TO THE EDITORS: Thank you for reviewing our article on "Auricular Fibrillation in Normal Hearts." The material for this article and the writing thereof came from the department of internal medicine of the Lahey Clinic.

HUGH H. HANSON, M.D.
Rochester, Minn.

¶Inadvertently we placed both authors of this article, Dr. Rutledge and Dr. Hanson, at the Mayo Clinic. Dr. Rutledge is with the Lahey Clinic. So, too, was Dr. Hanson at the time the article was written, but he has since become affiliated with the Mayo Clinic.—Ed.

Hot Water vs. Refrigeration

TO THE EDITORS: While practicing in Arabia, I encountered three times in homes where conditions were quite primitive such severe postpartum hemorrhages that the patients' lives were endangered.

Besides elevating the legs and giving pituitrin, I gave a douche of water as hot as could be tolerated. A teaspoonful of tincture of iodine was put in the water. An ordinary enema can with a sterile nozzle was used.

In all 3 cases this heroic and unscientific measure did the trick. There was no more bleeding and the patients lived.

I adopted the measure at the suggestion of my Indian nurses who were trained as midwives and had observed its effectiveness in India.

I would not think of using this measure before trying the usual methods of control, as patients do not enjoy it. In the cases mentioned, it was a last resort—but bleeding stopped.

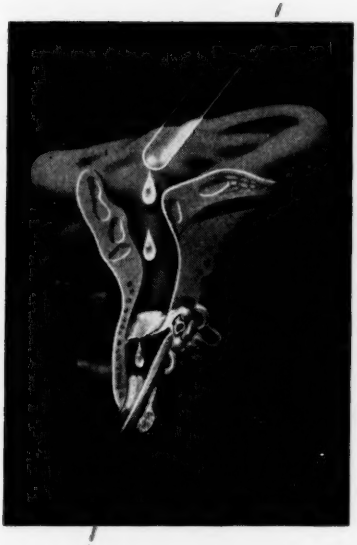
You may send this to Dr. Frederick M. Allen if you like. I noticed his letter about the use of refrigeration in obstetric crises in your Medical Forum recently (Sept. 15, 1949, p. 78). I'm a little doubtful whether he or most doctors will think very highly of my method, but it might conceivably save a life if some doctor caught in a home is at his wits' end to save a life, as I was.

NEOSKOLETA TIFFANY, M.D.
Inglewood, Calif.

Hysteria in Children

TO THE EDITORS: The term hysteria may be used in either a general or precise manner. It has been used loosely to describe any type of emotional reaction—"hysterical attack." However, in its more precise form

complete topical treatment for middle and external ear infections



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it is usually considered to represent a conversion phenomenon. In this mechanism the individual's conflict is converted or changed into a physical symptom, usually with the loss of the normal anxiety and tension that accompany such a conflict.

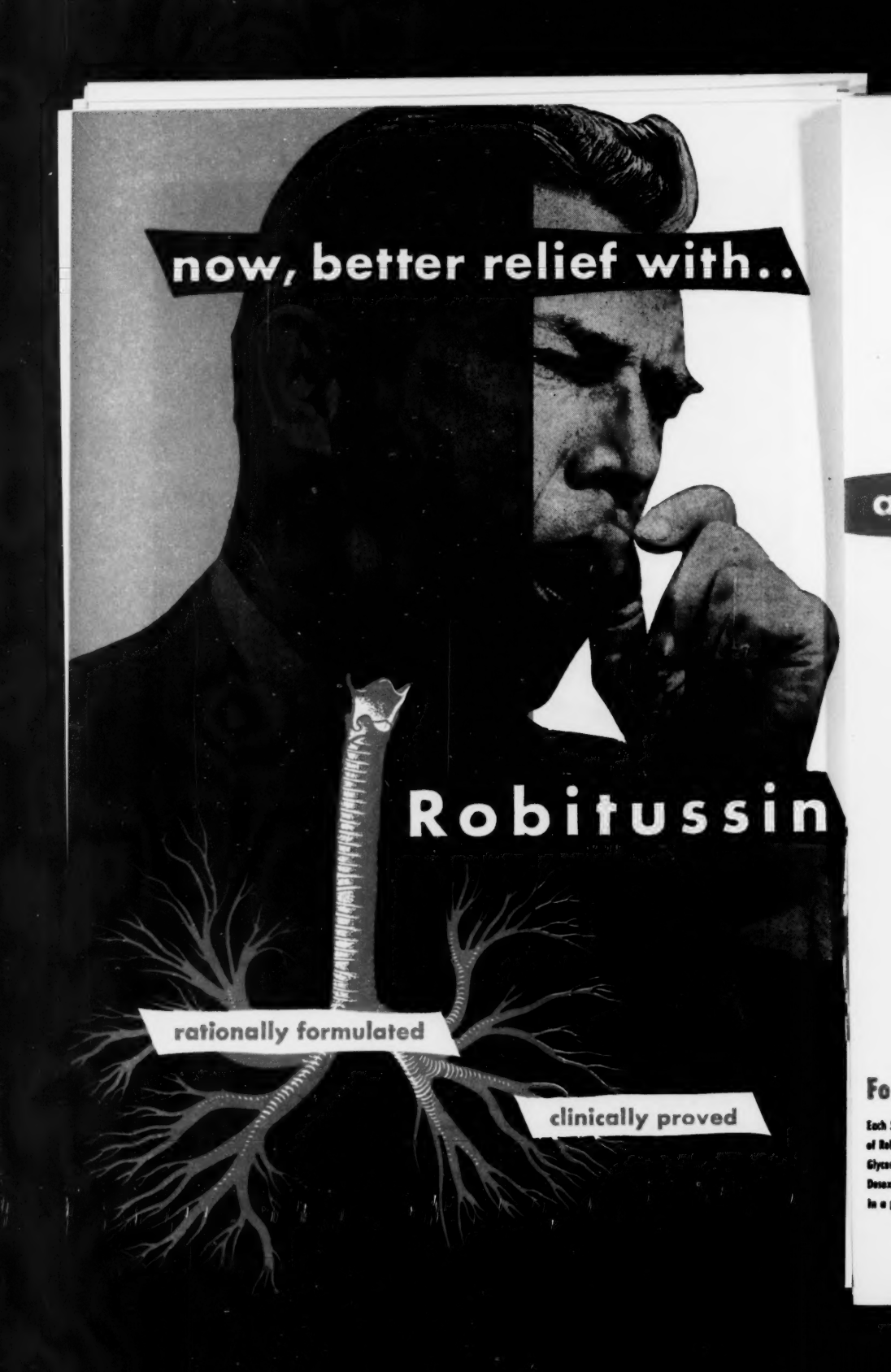
Such patients may have a paralysis of the hand that is accepted with other types of psychoneurotic reactions in which the individual develops physical symptoms but retains the anxiety and tension associated with his problems. In these neurotic reactions he may have disturbances of heart, bladder, or bowel due to the normal psychosomatic reaction associated with such moods as anger, fear, or anxiety.

A true hysteria of the type usually found in adults and described above is a somewhat rare occurrence in childhood. In many instances the whole mechanism appears very close to consciousness and one often suspects that the child is deliberately putting on these symptoms in order to solve his problems.

Such symptoms are of value to the child, usually in one of two ways—by enabling him either to avoid an unpleasant situation or to obtain attention, affection, and increased security. It may well be that the basic mechanism is the same in both the child and the adult and that the difference in the final picture depends upon the emotional maturation of the two individuals, their life experiences, and their intellectual levels.

Hysterical reactions in children, while arising in various situations, are most commonly seen in relation to a school situation, when the child is having difficulty with the work and is falling behind his classmates. The

(Continued on page 28)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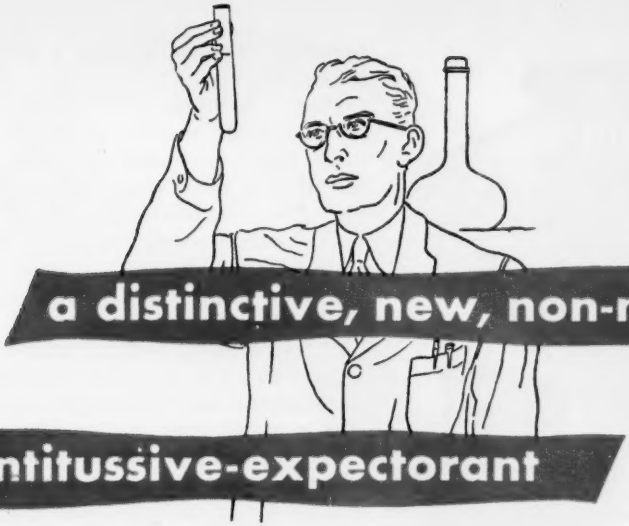

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Glyceryl guaiacolate has proven an effective aid to expectoration, and a cough ameliorator with prolonged action, through its increase in and thinning of respiratory tract fluid;[1,2,3] yet it has no ill effect upon digestion.[1]

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REFERENCES: 1. Connell, W. F. et al: Canadian Med. Assoc. J., 42:220, 1940. 2. Perry W. F. and Boyd, E. M.: J. Pharm. Exper. Ther., 73:65, 1941. 3. Stevens, M. E. et al: Canadian Med. Assoc. J., 48:124, 1943. 4. Foltz, E. E. et al: J. Lab. Clin. Med., 28:603, 1943. 5. Graham, B. E.: Ind. Eng. Chem., Ind. Ed., 37:149, 1945. 6. Schulz, F. and Deckner, S.: Klin. Wochschr., 21:674, 1942.

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Glyceryl Guaiacolate, 100 mg.
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In a palatable aromatic syrup.

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for *rational* cough management

hysterical reaction to such a situation is usually one that will solve the problem: paralysis of the writing hand, a disturbance of vision which keeps him from seeing the board, a disturbance of hearing which prevents him from following the teacher, or abdominal complaints and pains which are usually most evident in the early morning and prevent him from attending school.

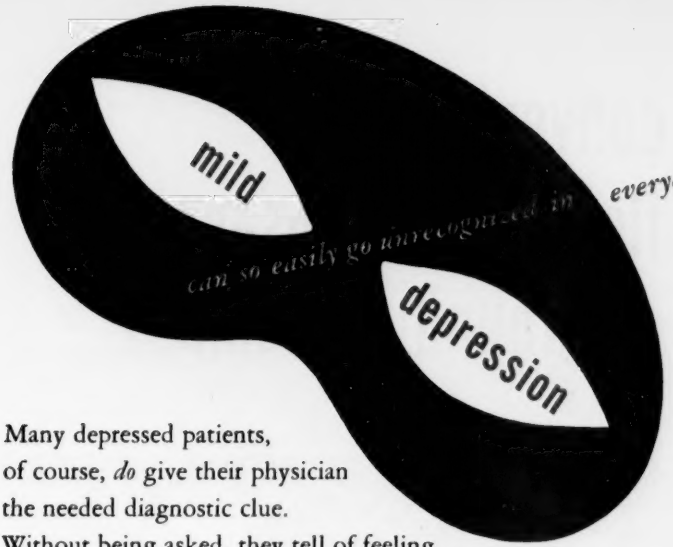
When the hysteria is secondary to a disturbance in the home situation, the pattern is more likely to be varied, but is usually one that enables the child to obtain more attention and affection from the members of the household or elevates him into a preferential position compared to his brothers and sisters.

The treatment of hysteria requires a full explanation of the cause of the symptoms to the parents. Therapy must also be directed toward correcting the basic situation.

If the difficulty is in school, it may mean less pressure by the teacher, extra coaching, or placement in a lower grade or an opportunity class. If the origin of the symptoms lies in the home, which incidentally is a much more difficult situation to control, an attempt must be made to improve the relation between the parents and the patient and the patient and his siblings. This must be worked out on a more wholesome and satisfactory basis, one that will lead to an eventual sense of acceptance and security on the part of the child. In addition to this, one should see that the child is not allowed to escape situations through the utilization of such symptoms nor obtain excessive attention or prestige through such symptoms.

W. A. HAWKE, M.D.

Toronto



can so easily go unrecognized in everyday practice

Many depressed patients, of course, *do* give their physician the needed diagnostic clue. Without being asked, they tell of feeling "tired all the time" or "despondent" or "lethargic." Countless thousands of others, however, will run to their physician with every small somatic complaint and yet never mention what really troubles them most: their depression—a condition that so often leads to physical as well as mental break-up.

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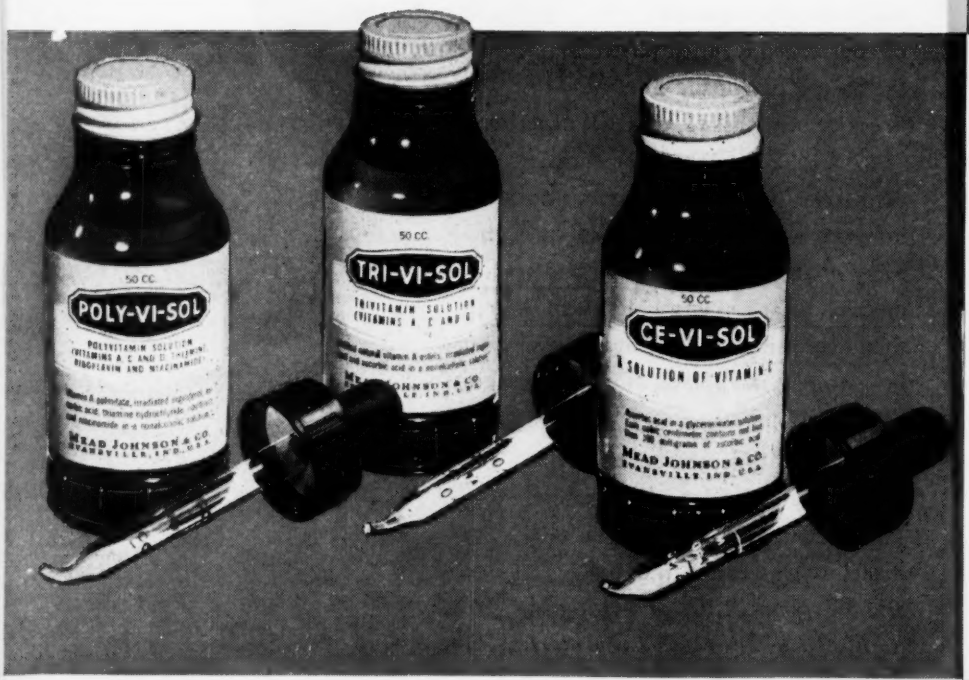

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Therapy for Aphthous Stomatitis

TO THE EDITORS: I fully agree with Dr. J. M. McMahon's conclusion relative to the psychosomatic etiology of certain cases of aphthous stomatitis, that terribly disturbing condition about which so little mention has been made in the nation's medical literature (Sept. 15, 1949, p. 18). Another discouraging phase of this condition has been the long list of therapeutic suggestions, few of which are even worth trying.

In four decades of practice, I have encountered few conditions so responsible for localized poignant pain in the region where these oval-shaped, pearly tinted, ulcer-like sloughs occur. I have had patients state emphatically that if they had to choose between the intense pain of a furuncle or carbuncle and the patch of an aphthous stomatitis, they would much prefer the former. I doubt very much whether there are many conditions in the practice of medicine which find a physician so thoroughly helpless.

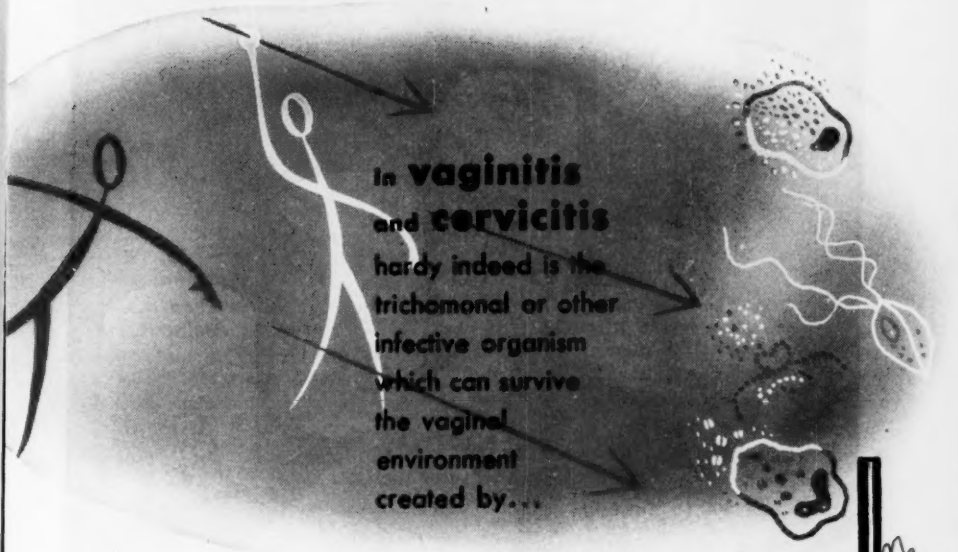
Recently I encountered a case of a very persistent type which was frequently recurrent for over a year. My reaction, I imagine, was like most physicians' when called upon to treat this disturbance. One of the ulcers seemed to be unduly irritated, and since the patient was a middle-aged individual, I called into consultation a competent specialist in cancer and allied conditions, who nevertheless does not overlook his general therapeutics.

His decision was to place the patient on large doses of a high potency yeast powder. Progress has been somewhat slow but definite, and it does appear at this time that the condition will clear up.

WILLIAM HARVEY THALER, M.D.
Long Beach, Calif.

how to get rid of

undesirable tenants



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Washington Letter

Physician's Interest in National School Health Program

Before long, most physicians will come into direct contact with provisions of the national school health law. This program authorizes federal assistance to states by a formula that allows a larger per-pupil allowance for the low-income sections. A total of $35,000,000 is provided for these grants.

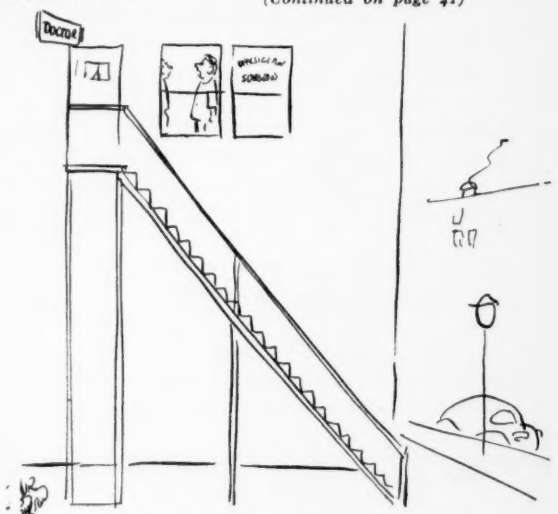
The basic idea is to insure that no American child shall come to adult life with physical or mental defects or conditions which can be prevented or corrected at an early age. To this end, the program provides aid to the states for "prevention, diagnosis and treatment of physical and mental defects and conditions of all school children, with special reference to the correction of defects and conditions likely to interfere with the normal growth and development and educational progress of children."

The plan originally was attached to the general federal aid to education bill. Sen. Elbert Thomas of Utah, chairman of the Senate committee, made it a separate bill early in the last session of Congress. He anticipated the possibility of a controversy over aid to private and religious schools and decided that, on health, this argument should not be allowed to arise. As a result, all children will receive the same attention, whether public, private, or parochial pupils.

For the private physician, several points in the law deserve careful attention when funds become available on the local level.

1 The law requires that medical and dental examinations be provided at the schools, as long as any federal funds are available for the purpose.

(Continued on page 41)



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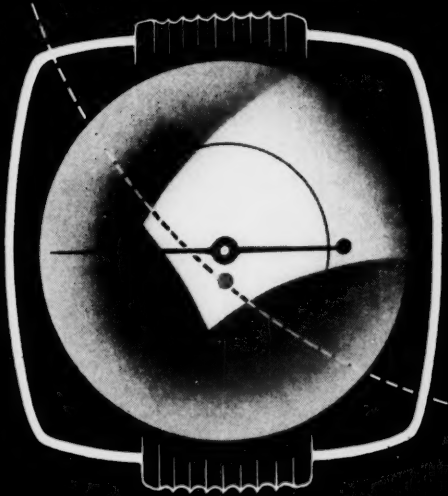

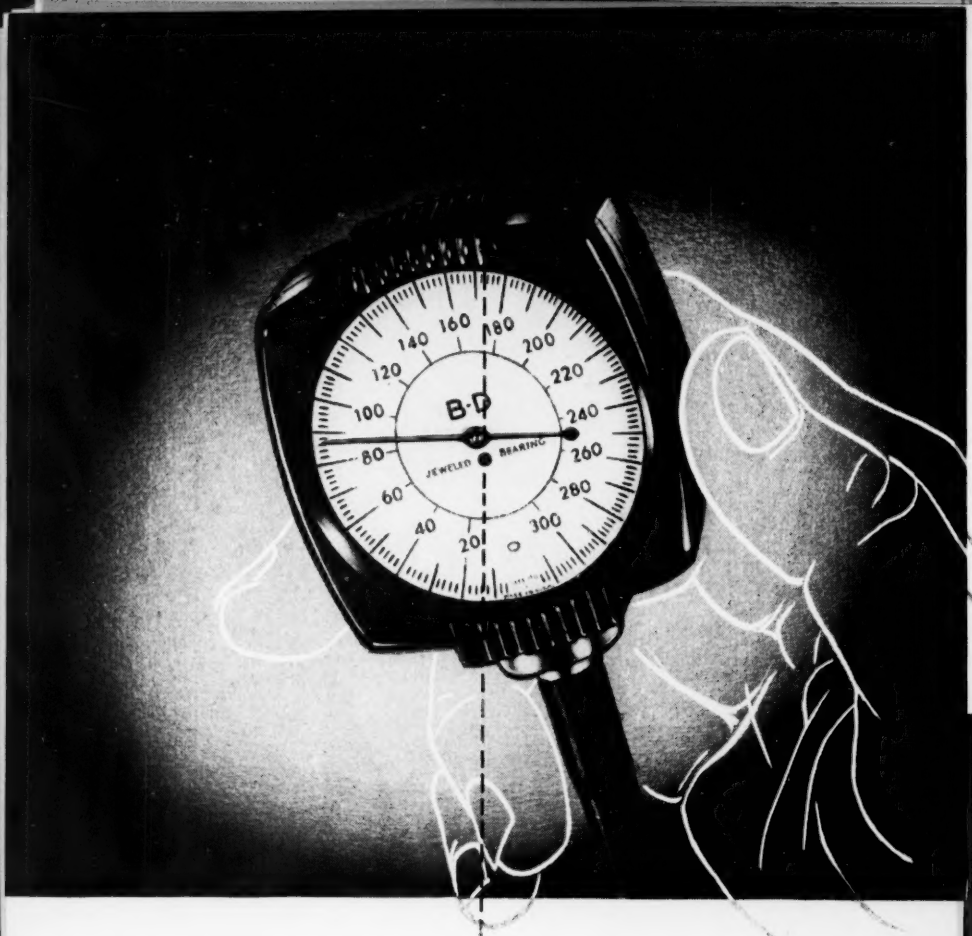

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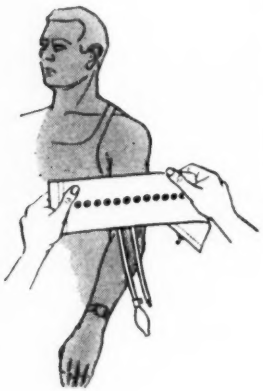

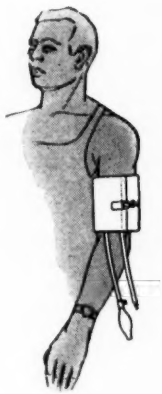

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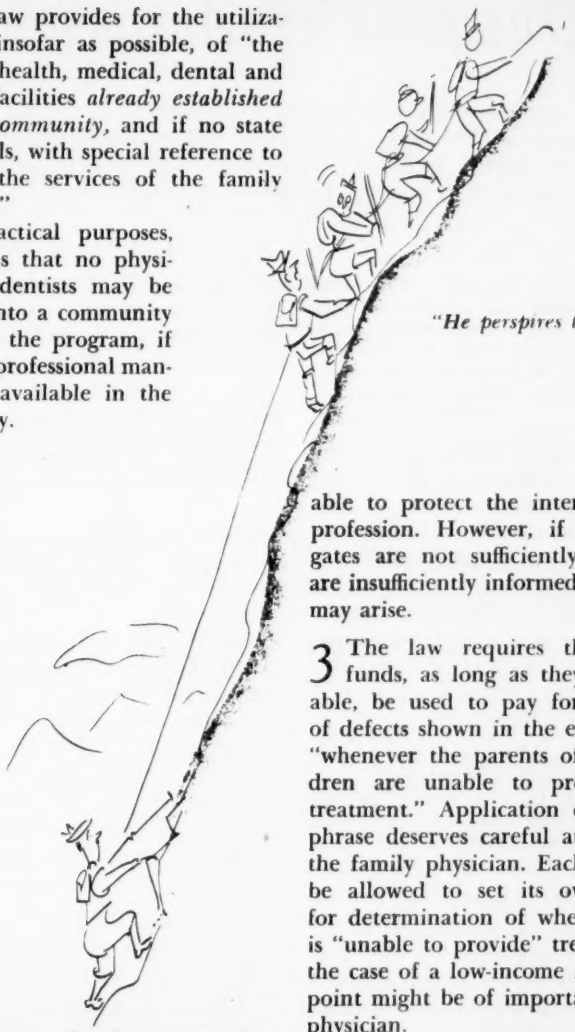
2 The law provides for the utilization, insofar as possible, of "the qualified health, medical, dental and hospital facilities *already established in each community,* and if no state law forbids, with special reference to utilizing the services of the family physician."

For practical purposes, this means that no physicians or dentists may be brought into a community to handle the program, if adequate professional manpower is available in the community.



"He perspires too freely."

Furthermore, the law states that representatives of professional associations shall be members of a state committee to advise the state health department in administration of the act. Active and well-informed representatives on these boards should be able to protect the interests of the profession. However, if these delegates are not sufficiently active, or are insufficiently informed, difficulties may arise.

3 The law requires that federal funds, as long as they are available, be used to pay for treatment of defects shown in the examination "whenever the parents of such children are unable to provide such treatment." Application of this last phrase deserves careful attention by the family physician. Each state will be allowed to set its own criteria for determination of when a family is "unable to provide" treatment. In the case of a low-income family, this point might be of importance to the physician.

4 A long-debated point is whether states should be allowed to let the plan cover treatments for all children, without a test of the family's ability to pay. As this is written, in

(Continued on page 146)

Questions & Answers

All questions received will be answered by letter directed to the petitioner; questions chosen for publication will appear with the physician's name deleted. Address all inquiries to the Editorial Department, MODERN MEDICINE, *84 South Tenth Street, Minneapolis 3, Minnesota.*

QUESTION: A man thirty-five years old had a compound fracture of his left tibia and fibula about fifteen years ago. The leg healed well, but the left calf is now 2¼ in. larger than the right. Kindly advise the proper procedure.

M.D., New Jersey

ANSWER: *By Consultant in Orthopedics.* The difference in size of the two calves probably cannot be adjusted without surgery; it is doubtful that overexercise of the smaller calf would provide permanent increase in bulk of muscle. If no symptoms other than discrepancy in circumference exist, it would be best to accept the circumstance.

QUESTION: I have a young patient in her second month of pregnancy who has severe leg cramps at night. Can you tell me what causes the cramps and what to do to prevent them?

M.D., New York

ANSWER: *By Consultant in Obstetrics.* The cause of leg cramps during pregnancy is not entirely clear. The most popular theory is that calcium deficiency leads to tetanic contractions of the muscles of the lower extremity. These occur during sleep because the circulation becomes stagnant in the absence of muscular contraction. Trousseau's sign is based on similar conditions in the upper extremity except that the vascular stasis is artificially produced. The advocates of the above theory attempt to increase the calcium intake to combat the cramps. Others have suggested thiamine deficiency as contributory and give large doses of vitamin B_1. Fortunately, massage and walking promptly relieve most patients.

QUESTION: Could you give me references on the use of urine injections in the treatment of urticaria?

M.D., New Mexico

ANSWER: *By Consultant in Dermatology.* The use of protein extracts from urine in treatment of urticaria was suggested in England some years ago but, as far as I know, the treatment has not been followed there and certainly not in this country. The following references are suggested:

1] Herz, K: Ueber eigenharnbehandlung. *München. med. Wchnschr.* 78:398-400, 1931.

2] Gutiérrez, P., and Dionisio, S. A. Autourotherapy in urticaria. *Acta med., Philippina* 2:427-433, 1941.

3] Jausion, H., and Paléologue. Une nouvelle méthode de désensibilisation; l'auto-ouro-thérapie dans la cure de l'eczéma. *Bull. soc. franç. de dermat. et syph.* 36:115-118, 1929.

4] Jausion, H., Carrot, E., and Gibert, A. Un cas d' eczéma solaire spontané. Sa brusque généralisation après application de pommade. Sa guérison l'auto-ouro-thérapie. *Bull. Soc. franç. de dermat. et syph.* 38:9-14, 1931.

5] Johnston, H. A. Autodesensitization of allergic conditions. *California & West. Med.* 4:307-309, 1934.

6] Nicastro, A., and Petronici, G. L'autouroterapia in dermatologia. *Riv. san. siciliana* 26:867-872, 1938.

7] Tereshkovitch, V. I., and Tokareff, A.P. Autourinotherapy in skin diseases (in Russian). *Vrach. gaz.* 34: 1583-1586, 1930.

QUESTION: Can you recommend treatment other than x-ray for keloids?
M.D., Georgia

ANSWER: *By Consultant in Dermatology.* The best treatment for keloids is probably radiotherapy by x-rays or radium. Nevertheless some cases are resistant and other measures may be applied. Occasionally a satisfactory result is obtained with application of solid carbon dioxide. Small lesions can sometimes be treated successfully by shaving with a sharp blade and then light electrofulguration.

Keloidal reaction may occur in one scar but not in others in the same individual. Under this circumstance excision may be tried and the site watched closely for evidence of new keloidal development. If the area has not previously had large amounts of radiotherapy, that treatment may then be given in order to prevent further keloidal change.

QUESTION: When is the sex of the fetus determined?
M.D., New York

ANSWER: *By Consultant in Genetics.* Sex determination probably occurs at the time of conception and depends upon the type of chromosomes carried by the sperm. Secondary sexual characteristics may be influenced by maternal hormone production. Sexual development has been influenced by extrinsic hormone administration in animals but not in human beings.

QUESTION: For about eight years a woman twenty-eight years old has had a temperature fluctuating daily from 98 to 101° and often to 103°. Her only other complaints are morning fatigue, headaches in the morning and evening, and an ache in her left arm. All laboratory data are negative. Recently she took aureomycin, 16 capsules, 250 mg. daily, for two days. Temperature was normal for a day or two but now rises daily to 101°. She has, however, felt better since taking aureomycin. Can you suggest a diagnosis?

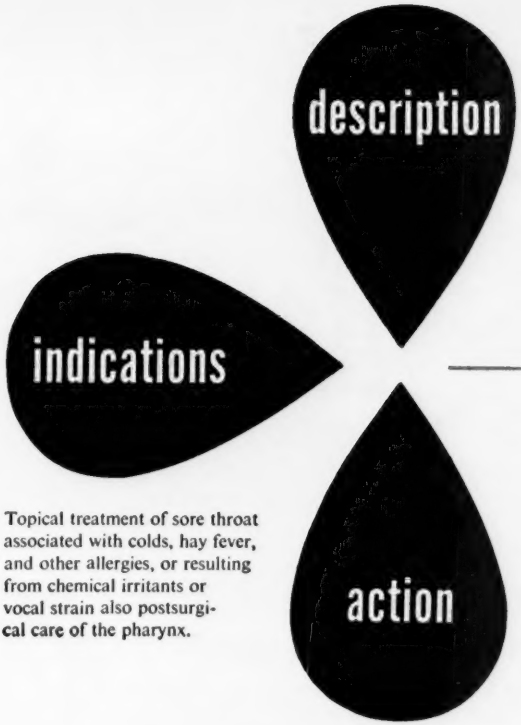
M.D., California

ANSWER: *By Consultant in Internal Medicine.* The temperature variations described, if known by accurate observations for a period as long as eight years, are probably normal for the individual. Similar cases have been reported, notably by Hobart Reimann. Morning fatigue and evening headache are usually psychogenic symptoms and are not related to changes of body temperature or to a particular disease.

QUESTION: Could you give me the technic, or reference, for artificial insemination along with precautions and contraindications? I have a married patient, age twenty-nine, who is very anxious to become pregnant.

M.D., Kansas

ANSWER: *By Consultant in Obstetrics.* Excellent results have recently been reported by Douglas P. Murphy, M.D., and Edmond J. Farris, Ph.D., utilizing the rat ovulation test to detect the day of ovulation. Their technic is reported in *J.A.M.A.* 138:13 (Sept. 4) 1948. The basal temperature record may also be helpful for timing purposes. Evidence of infection in either the semen or the cervix is a contraindication to artificial insemination. Obviously, complete sterility studies must precede insemination and reveal no serious obstacle to conception.



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James L. Tullis, M.D.
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Forensic Medicine

COMPILED BY ARTHUR L. H. STREET, LL.B.

PROBLEM: [1] When licensed as an obstetrician and chiropractor, is one under the same legal responsibility as a general medical practitioner in the treatment of postparturitional conditions? [2] Is the liability for negligence in diagnosis and treatment diminished by the temporary entrance into the case of a regular physician for the purpose of delivering a stillborn child? [3] In such cases, does the fact that defendant is a chiropractor and midwife disqualify a regular medical practitioner from testifying as an expert as to the sufficiency of the diagnosis and treatment, the witness knowing what a midwife actually does or should do under given conditions?

COURT'S ANSWERS: [1] Yes. [2] Yes. [3] No.

This decision was made by the Illinois Appellate Court, First District. Third Division (84 N. E. 2d 843).

PROBLEM: A sprained ankle sustained by a railway passenger on a station platform rendered her a permanent cripple. Was she necessarily debarred from collecting damages from the railway company to the extent that her injury was aggravated by her failure to consult a physician?

COURT'S ANSWER: No.

The Kansas City, Mo., Court of Appeals noted that the injured woman, apparently of moderate means, first thought that the sprain would yield to home treatment, although it was painful from the beginning. It was for the jury to say whether she was grossly neglectful in failing to consult a physician and in relying on "her own homely skill . . . . In many poor families physicians are not called except in extreme cases. Ordinary injuries, such as cuts, bruises, burns, and sprains are given none but home treatment. Courts should be slow to condemn as contrary to rules of law the ordinary practices and usages of the large class of people who must practice the closest economy to make ends meet" (140 S. W. 602).

PROBLEM: In a suit against a surgeon for an allegedly unauthorized subtotal hysterectomy, performed in Ventura, Calif., did the trial judge err in refusing to permit a Los Angeles surgeon, called to testify for plaintiff, to state that there was no emergency justifying the operation?

COURT'S ANSWER: No.

The California District Court of Appeal, Second District, Division 2, decided that the fact that Ventura lies in a rural community sixty miles away from Los Angeles, which possesses "many large modern hospitals," disqualified a Los Angeles surgeon from testifying to the correctness of practice in Ventura. Likewise, it was proper to exclude similar testimony of a doctor who had practiced in New York City and Los Angeles. It was a technical error to refuse to permit a third

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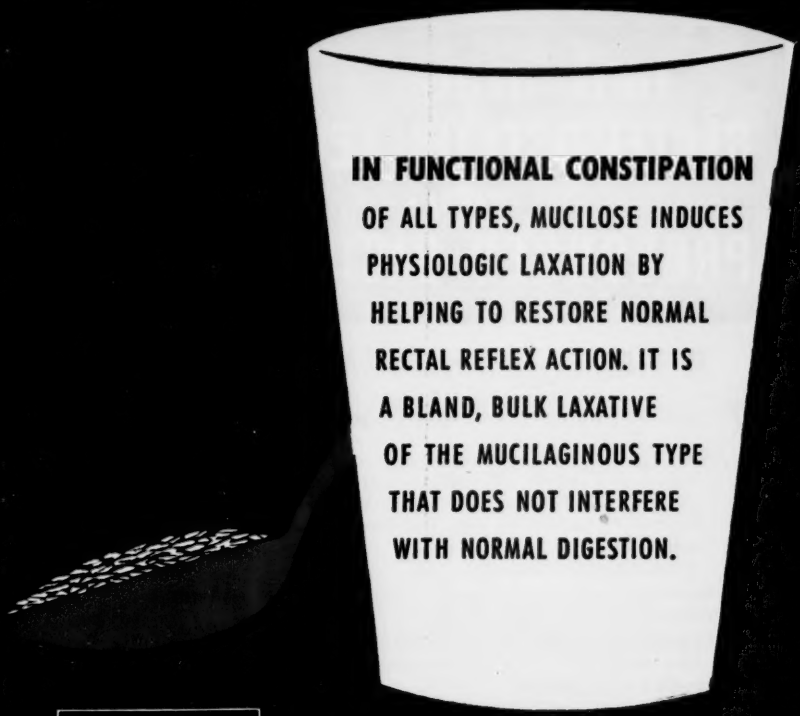
doctor who had practiced in Ventura County and an adjacent county to state whether the practice was the same in both counties, but the error was not prejudicial because a fourth doctor who resided in the county where the operation was performed testified for plaintiff that no emergency justifying the operation existed (208 Pac. 2d 68).

PROBLEM: An employee's claim for a workmen's compensation award for alleged injury to his spine was opposed by the employer because the claim was not filed within the time required by the compensation act. Was the employer debarred from asserting that defense, in the light of the following facts? The employee was treated by his own physician and did not consult the employer's doctor until he was ready to go back to work. The employer's doctor, examining the patient only to determine his fitness to return to work, made some indistinct roentgenograms and informed the workman that because of a muscular condition he was no longer fit for manual labor. Afterward a third doctor discovered that the employee had congenital back weakness and injury to the spine.

COURT'S ANWER: No, the employer was not barred from pleading delay in filing the claim.

The Utah Supreme Court decided that the employer's doctor's misdiagnosis was not fraudulent but, at most, due to lack of skill or care in reading the indistinct films. The court further decided that the patient reported to the employer's doctor only to determine his fitness to return to work and did not rely upon what the employer's doctor told him as to the nature of his injuries. The doctor who had treated him did not discover the injury, so why should the employer's doctor be regarded as having neglected to use good faith? (206 Pac. 2d 715.)



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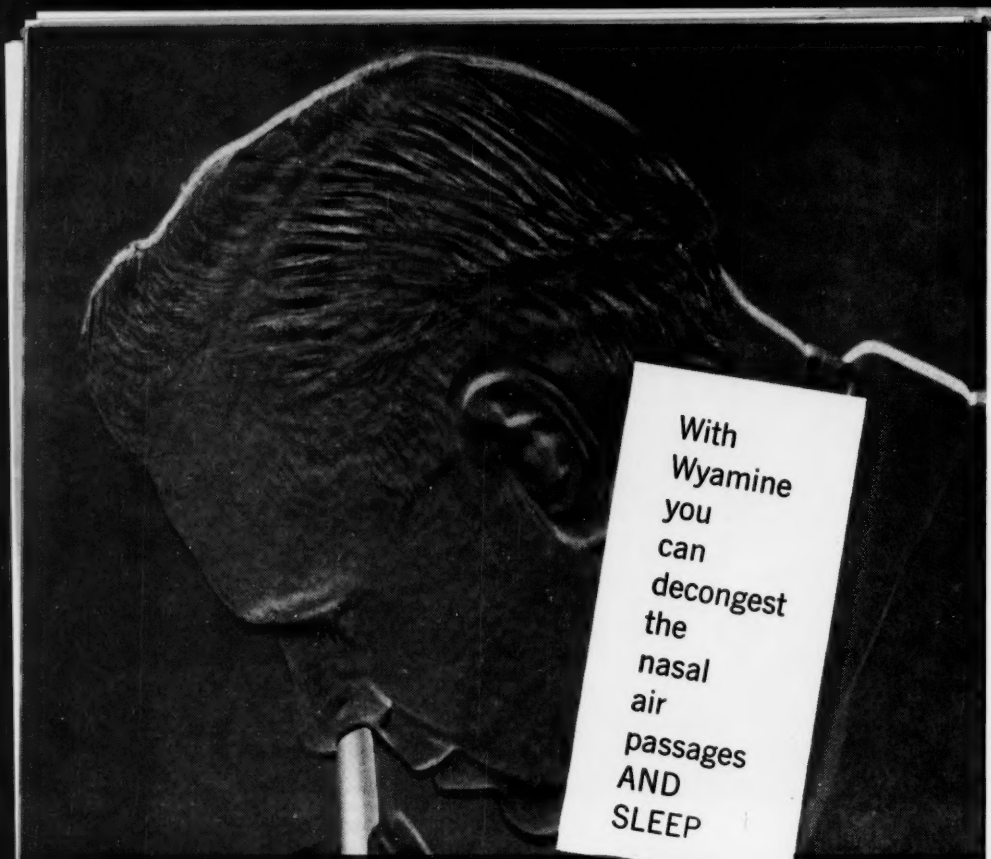

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Special Article

Papillary Adenocarcinoma of the Kidney

W. CALHOUN STIRLING, M.D.,* AND J. E. ASH, M.D.†

Prepared for Modern Medicine

A MAJOR problem in reducing the high mortality rate with kidney tumors lies in the difficulty of early detection of the lesion. Moreover, even though new urologic technics are rapidly decreasing diagnostic delay, the feasibility of surgery must be carefully weighed before treatment is undertaken.

The physician should constantly bear in mind that 50% of patients die within two years after removal of renal tumors.

OCCURRENCE

Papillary adenocarcinoma is the most common tumor of the kidney and occurs chiefly in patients between fifty and seventy years of age, more frequently in men than in women. Patients usually die within two years from general debilitation or metastasis.

The tumor is ordinarily solitary and located at a pole of the kidney, usually the lower. It attains great size and is frequently extremely vascular. Different portions vary greatly in appearance, being soft and yellow where the clear cells predominate and dark where there has been hemorrhage. Strands of fibrous stroma divide the cancer into lobules. There may be cysts or calcification secondary to cell necrosis.

The tumor tends to extend into the pelvis of the kidney and invade the renal vein. It may grow slowly and is often overlooked until metastasis is noted, usually in the lungs or bones.

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† Colonel, U.S.A. Retired.

As much variation may appear in the histology of the metastatic lesions as in the primary growth.

DIAGNOSIS

The symptoms of blood in the urine, pain, and mass in the flank are seen and, when concomitant, make the diagnosis of kidney carcinoma obvious. These warning signs occur, respectively, in 50, 35, and 10% of all cases. Loss of weight and strength occurs in 15%.

Physicians must continue to impress the laity with the grave import of the passage of blood from the urinary tract. Such an occurrence demands an immediate examination. The amount of blood may be slight, yet may constitute the only indication of the tumor for a long time. Because bleeding may be painless, intermittent, and of short duration, the patient is often lulled into a false sense of security. Sometimes blood clots block the ureter, causing colic-like pain on the affected side.

A large mass in the loin is usually a late manifestation of tumor of the kidney and indicates a poor prognosis. Blood-borne metastases may cause gastrointestinal pain, constipation, jaundice, headache, cough, and shortness of breath. Fever, leukocytosis, hypertension, and varicocele on the affected side are frequent. Renal tumors become very large, are tender on pressure, and may not move with respiration.

When cancer of the kidney is suspected, a preliminary intravenous urogram should be done to ascertain the size, function, and appearance of the calyces and pelvis of the kidney. Then a cystoscopic study is made, including bilateral retrograde pyelograms and a differential function test.

Retraction, blunting, amputation, or absence of a major calyx is the most characteristic pyelographic finding and is observed in most cases. The tumor may extend toward the periphery and cause the calyx to have a "spiderleg" appearance. The number of calyces involved increases with the size of the growth, but a major calyx is usually primarily affected.

The examiner should not rely too much on the findings in a single pyelogram. We have seen 2 cases in which the outlines of the calyces and pelvis were normal in the retrograde pyelogram, yet deformity was found on intravenous study.

Other evidence of deformity includes compression of the kidney pelvis so that flattening, narrowing, or obliteration is

produced. Filling defects from blood clots or a tumor may be noted. The kidney is sometimes displaced laterally, superiorly, or medially. Abnormal insertion of the ureter is a very significant finding. Deformity of the ureteropelvic junction or alteration in the silhouette of the kidney is frequently observed.

By cystoscopic examination, hydronephrosis of the closed type may be difficult to differentiate from tumor, especially when the upper ureter is obstructed. Since nonrenal retroperitoneal tumor may displace the kidney considerably, renal mobility should always be calculated. There is less retraction of the calyces in polycystic kidney than in tumor. When retraction does occur, the calyces are broad, in contrast to the narrow calyces found in neoplasm.

The pyelogram in solitary cyst is often unaltered and the urine normal. The position of the kidney axis may be considerably altered by the weight of the cyst.

Other lesions to be considered in differential diagnosis are pyonephrosis, solitary or polycystic kidney, and infections producing hematuria and pyelitis cystica or glandularis. Ptosis or rotation of the kidney or a double kidney may be mistaken for tumor. In 5 cases we have found prostatic hypertrophy associated with renal cancer. Tumor of the kidney should be considered even with prostatism if blood is passed.

An exploratory operation, implying nephrotomy, is not indicated, particularly if preliminary roentgen-ray therapy has been given. Some kidney tumors are so radiosensitive that irradiation will cause marked shrinkage and erroneous conclusions may be made from the distorted pyelogram.

Occasionally, evidence of deformity is identified on intravenous pyelography, then proved erroneous by a retrograde pyelogram. In such instances the retrograde pyelogram should be repeated at regular intervals until the possibility of carcinoma is ruled out.

Aspiration biopsy may be performed in doubtful cases, particularly if cystic disease is a possibility. Arteriography should be considered if the surgeon is still unable to differentiate cysts and tumors of the kidney from other retroperitoneal masses.

TREATMENT

With a large fixed tumor of short duration, the advisability of operation is questionable, especially if the patient's condi-

tion is below par. In such cases, the mass is obviously highly malignant.

For such patients, a course of roenten-ray therapy has been used in the past. In Wilms's tumor, usually seen in the young, early surgical extirpation followed by roentgen-ray therapy is being used successfully. The size of a radiosensitive tumor may be greatly reduced by application of roentgen rays, though this modality does not make an inoperable tumor operable.

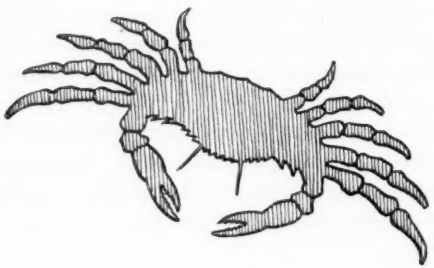
Metastasis should be sought before operation and roentgenograms made of the lungs, lumbar spine, pelvis, long bones, and skull. Metastases are more common with highly malignant tumors. The renal carcinoma has been extirpated in some cases in hope that its removal will decrease the metastatic process.

Calcification within the tumor indicates necrosis and has little bearing on the degree of malignancy.

The approach requires special consideration in surgery for a large kidney mass. We find the transperitoneal route very satisfactory. It offers a valuable method of obtaining early and adequate exposure of the pedicle and exploration of the renal vein so that the mass can be removed with less trauma and the tumor tissue is not squeezed into the renal vein.

The lumbar route is preferable for small tumors or if the pelvis of the kidney is involved or diagnosis uncertain. If the lumbar approach is used for removal of a large tumor, resection of one or more ribs will facilitate excision.

Postoperative radiation is rarely useful if removal has been complete.



Potassium Deficiency

J. W. HOLLINGSWORTH, M.D.*
Duke University, Durham, N. C.

HYPOKALIEMIA, low blood potassium, may be a feature of several disorders of metabolism or of diseases of the kidney or bowel.

The lack of potassium interferes with normal impulse transmission across the neuromuscular junction. The consequence is muscular weakness or paralysis. The electrocardiogram may reveal flattening of T waves, depression of the ST segments, and prolongation of auriculoventricular conduction.

J. W. Hollingsworth, M.D., summarizes the important features of several conditions which are often associated with potassium deficiency.

Periodic paralysis is a complex, usually familial, metabolic disturbance, beginning as weakness in the legs and spreading to involve other, sometimes all voluntary muscles. An attack lasts a few hours to several days and is often nocturnal in onset. Fatigue, exposure to cold, and overeating may precipitate the paralysis, which is always bilateral.

The disease is probably intimately associated with disturbed carbohydrate metabolism. Administration of potassium salts completely abolishes symptoms.

Infant diarrhea, when severe, can cause a loss of potassium. Sodium ions then move intracellularly to replace the potassium. Acidosis is thus increased. Potassium should be included in the fluid and electrolyte replacement therapy.

A recommended parenteral solution contains 2 gm. potassium chloride, 3 gm. sodium chloride, and 40 cc. molar lactate in 710 cc. of distilled water. From 80 to 150 cc. of the solution is given per kilogram of body weight daily. Potassium should not be given if urine excretion is suppressed because potassium intoxication may result.

Diabetic acidosis may be complicated by hypokaliemia. Several factors contribute to the potassium deficiency: dehydration, washing out of electrolytes by parenteral fluid therapy, and the utilization of potassium by glycogen deposition in the liver and muscles when insulin is given.

Therapy of diabetic acidosis should include total electrolyte replacement, not only sodium chloride and water.

Addison's disease treated with desoxycorticosterone is sometimes accompanied by hypokaliemia, especially when the patient is eating a low-potassium diet. The drug causes sodium retention at the expense of excessive potassium excretion.

Steatorrhea can increase loss of potassium in the feces. Unabsorbed intestinal fat combines with various bases, including potassium, to form

* The clinical significance of potassium deficiency. Bull. School Med. Univ. Maryland 34:1-10, 1949.

insoluble soaps which are excreted. Hypokaliemia as well as a calcium deficiency may result.

Prolonged alimentation by intravenous fluids alone may lead to potassium deficiency unless total electrolyte balance is maintained by proper electrolyte composition of the fluids given.

Chronic nephritis usually tends to cause potassium retention. Occasionally, however, potassium loss in the urine is excessive, resulting in potassium deficiency.

Cracking Joints

EDWARD E. BROWN, M.D.*

Low temperatures, high humidity, and the ionized air of storms are the principal weather factors predisposing to the cracking sounds heard when joints are flexed or hyperextended.

For four years, Edward E. Brown, M.D., of Ashland, Ore., recorded daily data about the cracking in his phalangeal joints and questioned other subjects. The phenomenon is common in winter, least frequent in summer. Cracking occurs during July in San Francisco, occasionally in Seattle and Portland, and rarely in New York City.

Cracking of joints is probably due to fibrositis. The inflamed fibrous connective tissue contracts; then, when the joints are flexed or hyperextended, the fibers stretch with a cracking noise. The tissue is lengthened after one or more cracks, and no sound is produced until the structures shorten again.

Cracking appears to be associated with nasal obstruction and postnasal drip, conditions also influenced by cool, damp weather.

* Cause of cracking joints; relation to weather and fibrositis. Northwest Med. 48:537-541, 1949.

INTRAMUSCULAR QUINIDINE GLUCONATE may be used for treatment of cardiac arrhythmia when a rapid effect is desirable or oral administration is not feasible. Samuel Bellet, M.D., and John Urbach, M.D., of the University of Pennsylvania, Philadelphia, find that the preparation is stable and nonirritating and produces typical effects as early as fifteen minutes after injection of 5 to 7.5 gr. Maximum results are obtained in ninety minutes. Quinidine by the intramuscular route does not entail the hazards of intravenous administration and may be lifesaving when quick relief is required from cardiac pain, intense palpitation, dyspnea, vomiting, or shock.

J. Lab. & Clin. Med. 34:1118-1120, 1949.

Endocrine Treatment of Alcoholism

JOHN W. TINTERA, M.D., AND HAROLD W. LOVELL, M.D.*

St. John's Riverside Hospital
Yonkers, N.Y.

New York Medical College
New York City

ADRENAL cortical extract and a high-fat, low-carbohydrate diet hasten recovery from acute alcoholism. The torturing period of drying-out is practically eliminated and recurrent craving much reduced.

Endocrine treatment was tried by John W. Tintera, M.D., and Harold W. Lovell, M.D., because of the frequent association of hypoadrenocorticism and chronic alcoholism. This adrenal cortex dysfunction seems to be constitutional in some habitual drinkers and acquired in others.

Many young alcoholics are asthenic in physique, with soft, smooth faces and overdeveloped breasts. Adrenal deficiency is shown by hypoglycemia, low 17-ketosteroids, and reduced androgens. Alcoholism is likely to develop at an early age in these subjects, unless strict self-control is exercised.

In a second type of chronic alcoholic, the adrenal cortex and other glands concerned in carbohydrate metabolism have been injured by prolonged intemperance. In most cases of alcoholic cirrhosis the lipoid content of the adrenals is decreased. Endocrine damage may be augmented by worry, grief, or other emotional stimulus.

Though causes differ, the same type of glandular imbalance appears in both types of inebriates. In the acute stage of intoxication lymphocytosis occurs, a further indication of adrenal deficit. During abstinent intervals, hypoglycemia is almost universal. The average fasting blood sugar level is 61 mg. per 100 cc., with a range of 54 to 80 mg. The glucose tolerance curve rises rapidly to moderate elevation, and becomes subnormal in two hours.

Hypoglycemia produces a craving for alcohol and symptoms resembling those of hyperinsulinism. The patient might resort to carbohydrates if he did not know that drinking gives him relief. As more liquor is taken, blood sugar is further reduced, hepatic glycogen is depleted, and fatty infiltration occurs. The liver is no longer able to detoxify estrogens, and men undergo feminizing changes.

Administration of adrenal cortical hormone reverses the entire process. Glycogen is mobilized from tissue protein, blood sugar raised, and hepatic function improved. Psychic and neurologic disorders, epigastric discomfort, and other symptoms subside.

* Endocrine treatment of alcoholism. Geriatrics 4:274-280, 1949.

For an acute alcoholic state, from three to five days of hospital care is often necessary and always desirable, though out-patient treatment may be successful.

On the first day in the hospital, 30 cc. of adrenal cortical extract is usually given by vein in three doses at intervals of six to eight hours. On the second, 20 cc. is injected in two doses, and for the next three days a single daily dose of 5 to 10 cc. Sedation is seldom required.

After discharge from the hospital, 2 to 5 cc. of the hormone is given intramuscularly twice a week for three weeks, then weekly as long as needed, sometimes for several months.

During and after hospitalization the diet should be high in fat with moderate amounts of protein and little carbohydrate, to prevent sudden fluctuation in the blood sugar level. Vitamin supplements are unnecessary.

Anorexia is overcome by 10 to 15 units of protamine zinc insulin per day injected subcutaneously. For testicular atrophy or other feminizing effects, testosterone propionate may be administered. In women, menopausal symptoms are relieved by testosterone with or without estrogens.

The complete program of Alcoholics Anonymous also should be utilized.

Special psychiatric therapy is reserved for the small group of patients with major psychoses.

RENNIN ESTIMATION of urine may aid in verifying diagnosis of pernicious anemia in patients with gastric achlorhydria without interrupting liver therapy, reports Ole Sylvest, M.D., of Sundby Hospital, Copenhagen. A 10-cc. sample of urine is collected before breakfast, acidified, and compared to a known solution. Rennin content is stated in rennin units per 10 cc. of urine, 1 rennin unit being equal to 0.1 mg. of pepsin Medicinalco (1/3,000). If values above 0.3 rennin units are found, likelihood of pernicious anemia is small.

Acta med. Scandinav. 133:346-349, 1949.

INCIDENCE OF HYPERTENSION in patients with portal cirrhosis is significantly lower than in the general population. These conclusions are reached by Samuel D. Spatt, M.D., and Philip Rosenblatt, M.D., of Jewish Hospital, Brooklyn, after analyzing the blood pressures, heart weights, or both of 60 bed patients over forty years of age who died of portal cirrhosis. Only 18% of the cirrhotic patients had hypertension, although over 50% would be expected to have the disease at that age. Incidence of abnormally heavy hearts was also significantly low among the patients.

Ann. Int. Med. 31:479-483, 1949.

Radioactive Iodine in Thyroid Diagnosis

D. G. Arnott and Associates, London*

Thyroid dysfunction is shown by radioactive iodine in urine after a tracer dose. Normally, half is concentrated in the gland and the residue excreted.

Healthy, thyrotoxic, and hypothyroid subjects were tested by D. G. Arnott, E. W. Emery, Russell Fraser, M.D., and Q. J. G. Hobson, M.A., of Postgraduate Medical School of London, England.

Potassium iodide, 10 μg. containing 10 microcuries of I^{131}, is diluted to 50 cc. As a standard for urine estimation, 5 cc. is pipetted into 20 cc. of 1% potassium iodide solution. The rest of the solution is taken orally after overnight fasting, and 2 rinsings of the container are swallowed.

Urine is collected for forty-eight hours in four samples representing excretion during the first eight hours, the next four, the next twelve, and the final twenty-four hours.

The concentration of radioactive iodine in urine is compared with that in the standard solution by means of the Geiger-Müller counter for liquid samples. Activity in each specimen is expressed as percentage of the dose.

Thyrotoxicosis is shown by low values in the sample taken during the period eight to twelve hours after ingestion. The average level is 0.5%, in contrast to 7% for good health. Hypothyroid determinations for the second day are high, about 20% against a normal 3%.

* Urinary excretion of radioactive iodine as a diagnostic test in thyroid disease. Lancet 257:460-465, 1949.

Hepatic insufficiency may be ascertained by electrocolorimetric estimation of the turbidity of the patients' serum in distilled water. The method somewhat resembles MacLagan's thymol test, is not so sensitive, and is extremely easy to apply, explain D. Vincent, M.D., of Toulouse, and M. Girard, M.D., of Lyons, France. Four test tubes containing, respectively, 1, 0.5, 0.2, and 0.1 cm. of serum are filled to the top with distilled water. Turbidity is evaluated in one-half hour. The test is positive if the most intense reaction appears in the first two tubes and is above 60 electrocoloric degrees, according to Meunier's scale. The other dilutions do not show flocculation at this time except in very strongly positive cases.

Presse méd. 58:807-808, 1949.

The Menopausal Syndrome

ERNEST HOCK, M.D.*

Charles S. Wilson Memorial Hospital, Johnson City, N. Y.

THE vasomotor, neurogenic, and rheumatic symptoms of the menopause may actually be manifestations of urethral causalgia.

Men with prostatic disease have many complaints similar to those of women at the climacteric period. Simple therapeutic measures such as prostatic massage often alleviate the condition almost immediately.

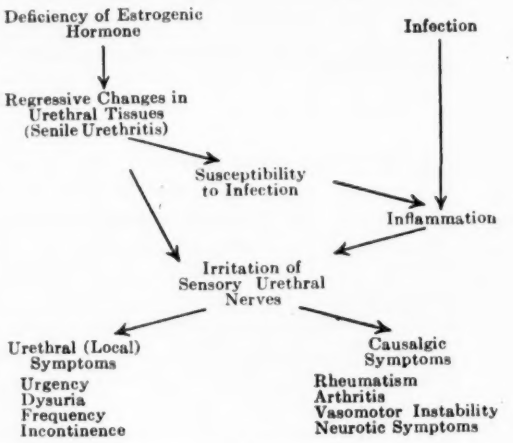
Since the female urethra is the homologue of part of the prostate, menopausal symptoms in women likewise may originate in the urethra, believes Ernest Hock, M.D. An irritative nerve lesion may be caused or aggravated by estrogen deficiency, which produces degenerative changes in the urethra. Senile urethritis may produce the nerve irritation or may create a susceptibility to a secondary infection. This theory is demonstrated in the diagram.

Organs other than the urethra may contribute to this process. Urethral causalgia cannot explain all the features of the menopausal syndrome. Probably nerve plexuses rather than individual organs should be considered. Hormonal imbalance may possibly increase the reflex irritability of the nervous system, and thereby initiate a causalgia.

Whether the theory is accepted or not, urethral therapy appears to relieve the menopausal discomfort when hormonal treatment will not. Administration of estrogens may have an indirect effect on these symptoms by correcting urethral disease.

Should estrogens and sedatives be ineffective, obvious urinary infection is treated. Otherwise, the amount of relief afforded by passage of a metal sound into the bladder for five to ten minutes should indicate whether the urethra is the source of the symptoms.

Theoretic Mechanism of Menopausal Syndrome



* The menopausal syndrome. New York State J. Med. 49:2078-2080, 1949.

Cystoscopy may be diagnostic if assay with a sound is inconclusive.

When the urethra and bladder neck are not diseased, 1% novocain solution may be injected into the bladder neck and posterior urethra. Prolonged comfort from this maneuver suggests that the menopausal symptoms in all probability arise in the urethra.

The use of sounds, novocain infiltration, and, occasionally, roentgen irradiation all have therapeutic value in the menopausal syndrome. Patients who have residual urine may be relieved by transurethral resection of the bladder neck.

Many of the symptoms of the male climacteric may also be alleviated by therapeutic treatment of the prostate. This fact suggests that the syndrome is likewise the result of a causalgic process. The rejuvenation which apparently takes place after prostatectomy may also be attributed to the relief of nerve irritation.

Safe Induction of Pneumothorax

I. J. Selikoff, M.D., I. G. Tchertkoff, M.D., and E. H. Robitzek, M.D.*

The needle used for initial pneumothorax usually pierces the lung and allows considerable escape of air. To prevent unwarranted laceration, pulmonary tissue should be motionless, the needle small, and insertion no deeper than necessary.

The technic of I. J. Selikoff, M.D., I. G. Tchertkoff, M.D., and E. H. Robitzek, M.D., of the Sea View Hospital, Staten Island, N.Y., is carried out at the bedside. No sedation, cough depressant, treatment room, or special aftercare is required.

The instrument is a 2-cc. or 5-cc. syringe fitted with a sharp, short-bevel needle about 1½ in. long, gauge 22 to 24. The syringe is half filled with sterile saline solution or 2% procaine and the site painted with iodine.

The patient is asked to take and hold a deep breath. The needle is advanced slightly, with constant upward pull on the syringe barrel. If no air bubbles into the solution a few breaths are allowed and the procedure is repeated. When air is obtained, the needle is immediately withdrawn.

In most cases air continues to flow, producing a visible pneumothorax cavity of 150 to 500 cc. Fluoroscopy is done soon after puncture, and six hours later a refill given with a 21-gauge needle.

When no space is seen the induction procedure is repeated; if several attempts fail the pleural space is probably obliterated.

* Initial pneumothorax: a new safe induction technique. Quart. Bull., Sea View Hosp. 10:93-100, 1949.

Anatomy and Repair of Varicose Veins

R. STANTON SHERMAN, M.D.*
University of California, San Francisco

FAILURE to eradicate incompetent perforator veins in the legs is the most common cause of persistence or recurrence of varicosities after operation.

Perforator veins in the thigh are much less frequently responsible for poor operative results since, contrary to previous opinion, these veins are seldom incompetent.

After performing numerous anatomic and surgical dissections of the lower limbs, R. Stanton Sherman, M.D., divides the perforating veins of the lower extremity into five main groups (see illustration). These groups are:

1] medial aspect of leg
2] lateral aspect of leg
3] lateral aspect of foot
4] short saphenous system
5] muscular perforators in the calf

The positions of the perforating vessels are fairly constant. The veins are readily located in terms of distance from the sole of the foot, as indicated in the figures. Some perforating veins pierce only the superficial fascia which extends into the leg from the thigh. Others drain into the deep venous system of the leg by way of intermuscular septa as well as through the deep crural fascia and through the muscles.

Perforator veins are also present on the medial aspect of the foot and ankle but are seldom of clinical significance there.

Optimum therapy of varicose veins should include high ligation of the long saphenous vein, eradication of the mid-Hunter perforator vein in the thigh, and excision of all incompetent vessels in the thigh, the leg, and the foot.

Sclerosing fluid injections may be employed to suppress bleeding. Minor varicosities may be injected locally before surgery.

Careful preoperative examination of the limb is mandatory. Large venous bulbs and palpable fascial defects are noted as frequent sites of varicosities.

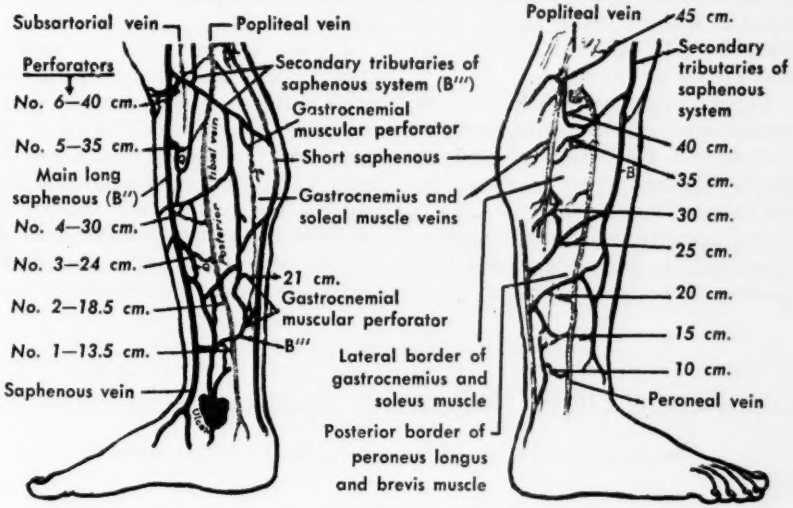
Spinal or general analgesia is best employed. After high saphenous ligation, 3 cc. of sclerosing solution is introduced into the saphenous vein. The saphenous vein in the thigh is then explored.

An oblique incision 4 cm. long is made on the inner aspect of the leg just below the knee. The saphenous vein in the leg is stripped digitally and incompetent perforator veins excised. A 3-cm. longitudinal incision is made at the medial border of the tibia about 25 cm. from the sole of the foot. This opening permits an adequate inspection of perforators 3 and 4.

Perforator vein 2 is most common-

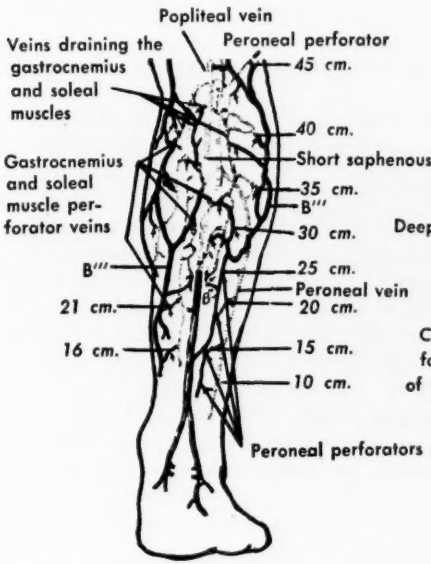
* Varicose veins: further findings based on anatomic and surgical dissections. Ann. Surg. 130:218-232, 1949.

DISTRIBUTION OF PERFORATOR VEINS

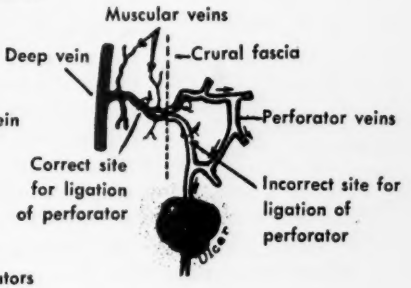


Medial aspect of the leg

Lateral aspect of the leg



Posterior leg perforators



Perforator pattern

ly incompetent and is exposed by a separate incision made 19 cm. from the sole and 1 cm. medial to the medial border of the tibia.

Other perforators which are suspected of being incompetent are then investigated by means of separate small incisions when necessary for satisfactory inspection.

Incompetent veins must be exposed extensively to allow the proper deep ligation, otherwise reflux of blood through tributaries will nullify results.

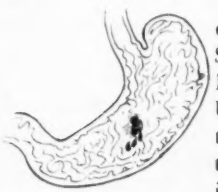
A positive result from a Trendelenburg test—incomplete filling of veins in thirty or more seconds—is inconclusive proof of the absence of incompetent perforator veins. Although in 95% of the cases operated upon the test was positive and competent perforator veins were thereby indicated, in 91% of the legs incompetent perforator veins were found.

Peptic Ulcer Following Splanchnicectomy

STEPHEN C. MASON, M.D., AND H. M. POLLARD, M.D.*

SYMPATHECTOMY for hypertension interrupts pathways of visceral sensation, including the typical midepigastric pain of peptic ulcer. Chronic ulcers may therefore become worse or new craters develop unnoticed until perforation or massive hemorrhage finally occurs.

Bleeding tendencies may be increased by gastric hyperactivity and by lack of vascular constriction.



Effects of bilateral splanchnicectomy and lower dorsal ganglionectomy were tabulated by Stephen C. Mason, M.D., and H. M. Pollard, M.D., at the University of Michigan, Ann Arbor. Ulcers were present before denervation in 8 patients of a large group and appeared postoperatively for the first time in 4, causing fatal bleeding in 2 of the latter.

If ulcer is active at the time of operation, severe bleeding may occur in a few days. Complications of recent or long-standing ulcers become more frequent and severe after splanchnicectomy.

Vague gastrointestinal complaints should be investigated without delay. An eroding ulcer may be indicated by distress or discomfort, soreness, fullness, sense of pressure, burning, tenderness, dull ache, or nausea and vomiting. Acute pain is usually associated with a serious complication. Immediately before death from perforation the only symptom of one patient was pain in a leg.

* Peptic ulcer following splanchnicectomy. Surg., Gynec. & Obst. 89:271-284, 1949.

Physiologic Basis for Burn Treatment

CARL A. MOYER, M.D.*
Southwestern Medical College, Dallas

NEGLECT of the uninjured parts of a burned or scalded patient may be fatal. Within a matter of minutes, the circulating mass of red blood cells may be reduced as much as 50%, and sodium and salt loss is rapid.

Hemolysis, blood stasis, petechial hemorrhages, and opening and dilatation of capillaries cause a rapid drop

TREATMENT IN THE THREE STAGES OF THERMAL INJURY

Stage	*Physiologic Changes*	*Treatment*
1] Shock and edema formation phase Begins with injury and ends 50 to 60 hr. later	Loss of circulating red cells and plasma proteins	No scrubbing of burned or scalded parts. This adds to initial injury and aggravates loss of red cells, etc.
		Transfusion of whole blood as soon as possible; give plasma or Hartmann's solution until blood can be obtained; give up to 3 or 4% of body weight in first 24 hr. and continue on subsequent days if pulse is still high and soft
	Growing edema of injured parts which induces deficit of extracellular fluid in uninjured parts of body	No water without salt unless signs of need appear
		3 gm. NaCl and 1.5 gm. $NaHCO_3$ per quart of cold water to drink; if vomited while shock exists, give Hartmann's solution intravenously; amounts must be gauged on clinical signs of adequacy or need
	Danger of ketosis, especially in children	Food, especially protein, in excess of 100 gm. per 24 hr., and carbohydrate in excess of 300 gm. per 24 hr.; hard candy

* Recent advances in the chemical supportive therapy of thermal injury. Texas State J. Med. 45:635-639, 1949.

TREATMENT IN THE THREE STAGES OF THERMAL INJURY—*(continued)*

Stage	*Physiologic Changes*	*Treatment*
2] Early recovery phase Starts with subsidence of edema and ends when separation of eschar begins	Delayed hemolysis	Transfusion of blood as required to keep hemoglobin above 10 gm. per 100 cc.
	Edema of injured parts decreasing	Stop salt water by mouth; give water ad libitum
	Tissue growth beginning	Food, including milk and meat, to give 200 to 400 gm. protein daily, and carbohydrate and fat to give 1,000 calories in excess of normal requirements
3] Phase of slough-separation, granulation, and epithelization	Loss of red cells, especially when dressings are changed	Transfusion of whole blood as for Stage 2
	Rapid expansion of capillary vascular bed in granulating areas	Salt water intermittently as required to make up for loss in excess of sodium salts taken in food
	Sodium loss through granulations	Food as in Stage 2
	Potassium loss through granulations while demand by growing cells is great	Never wet dressing with boric acid; it is "poisonous"
	Calcium loss through granulations	Never place patient in water; it also is "poisonous"
	Protein loss through granulations	Graft as soon as possible

in red blood cells per unit volume of uninjured tissue. If the reduction in the volume of circulating plasma is greater than the decline in volume of circulating red cells per unit of time, the hematocrit reading rises. An initially low hematocrit level indicates that red cells are being lost more rapidly than plasma is.

Extracellular fluid exudes from the undamaged to the burned tissues, first lowering plasma volume and later decreasing extravascular extracellular fluid. Electrolytes in extracellular fluid loss are chiefly sodium chloride and sodium bicarbonate. The reduction of sodium salts is more serious than the plasma protein decrease.

Supportive measures are essential. Treatment is based on restoration of physiologic changes and is largely directed toward getting whole blood, sodium salts, and water into the patient.

Blood and lactated Ringer's solution (Hartmann's) are immediately infused intravenously to combat shock, urinary suppression, and dehydration. When tolerated, liquids are given orally. A mixture of 3 to 4 gm. of sodium chloride (1 tsp.) and 1.5 to 2 gm. of sodium bicarbonate

or sodium citrate (⅔ tsp.) per quart of water is palatable and averts the acidosis that results from administration of normal saline. Oral saline fluids are discontinued when tissue edema begins to subside (see table).

Water intoxication, points out Carl A. Moyer, M.D., is caused by overloading the severely burned patient with plain water by mouth before adequate amount of salt is given. The water accumulates in the stomach, absorbs sodium salts, and is vomited. The water that held the salts in the plasma remains and dilutes intracellular and extracellular salts. If the fluid is not retained in the stomach but enters the intestine, body salts are still diluted.

Symptoms of headache, tremors, twitching, blurring of vision, vomiting, diarrhea, disorientation, salivation, mania, and even convulsions are caused by excessive water intake and are at times seen in early toxic phases of burns.

No plain water is given by mouth for seventy to one hundred hours unless indicated by severe thirst, dry mucous membranes, rising temperature, and plasma sodium concentration over 138 milliequivalents per liter.

If immersion or massive wet dressings are employed to clean wounds and control infection, the wetting agent must be an isotonic saline solution, 8 gm. of sodium chloride per liter. If water or hypotonic salt solutions are used, sodium salts are drawn into the dressings or bath water, and water enters the body. These changes cause salt-lack shock combined with water intoxication, a rapidly fatal syndrome.

Dressings covering the chest and abdomen should be loose. Pulmonary edema, pulmonary congestion, and atelectasis are easily produced by restriction of breathing. Even a slight impediment to breathing may be fatal to the severely burned.

Ketosis, frequent in children, can be prevented by giving sugar, as hard candy.

Deficiencies of potassium and calcium consequent upon loss from large granulating areas are remedied by high dietary protein, especially milk, meat, and fish.

Traction and Suspension for Fractures

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Columbia-Presbyterian Medical Center, New York City

THE objectives in therapy of compound fractures are reduction and maintenance of alignment, restoration of function of the soft tissues, and protection against additional injury.

In attaining these goals, Frank E. Stinchfield, M.D., finds traction in balanced suspension and fixed traction of great benefit. Traction may be exerted by means of adhesive applied to the skin or by pins or wires through bone.

When skin traction is employed the surface is thoroughly cleansed and the adhesive is smoothed to avoid any wrinkling or excoriation.

An ace bandage is applied in such a fashion that it leaves the upper end of the adhesive exposed so that any slipping may be noted. Skin traction is not recommended for old people, as large areas of tender flabby skin may be avulsed.

When more than a few pounds of traction are required with fractures of the upper extremity, skeletal traction is more comfortable to the patient and more efficient, therapeutically, than skin traction.

For forearm fractures a wire is inserted through the second, third, and fourth metacarpals. The hand is gripped to flatten the metacarpals (Fig. 1*a*) so that the pin may be inserted as shown in Figure 1*b*. Figure 1*c* illustrates incorrect pinning without manual depression of the bones.

The forearm should be in a vertical position with countertraction applied either by a broad sling to the arm with weights attached or by a pin or wire through the upper ulna.

For fractures of the humerus, a wire or pin is inserted through the upper part of the ulna, avoiding the upper cartilaginous area in children. The wire should be inserted from within outward to prevent injury to the ulnar nerve. Traction may be exerted horizontally with the arm parallel to the body, the elbow flexed 90 degrees, and the forearm suspended vertically.

In an alternative method, shown in Figure 1*d*, the arm is flexed at the shoulder with the forearm over the head and traction is exerted vertically.

For metacarpal and phalangeal fractures, a heavy needle may be passed through the phalanx and countertraction provided by a banjo splint (Fig. 1*e*, *f*).

In skeletal traction of the lower limb the following conditions should obtain:

► Weights should hang free and cords run easily through different pulleys.

► Leg and thigh slings should be smooth and always provide equal pressure.

► The suspension weight should

* The principles of traction and suspension in the treatment of fractures. South. M. J. 42:770-776, 1949.

TRACTION FOR FRACTURES OF UPPER EXTREMITY

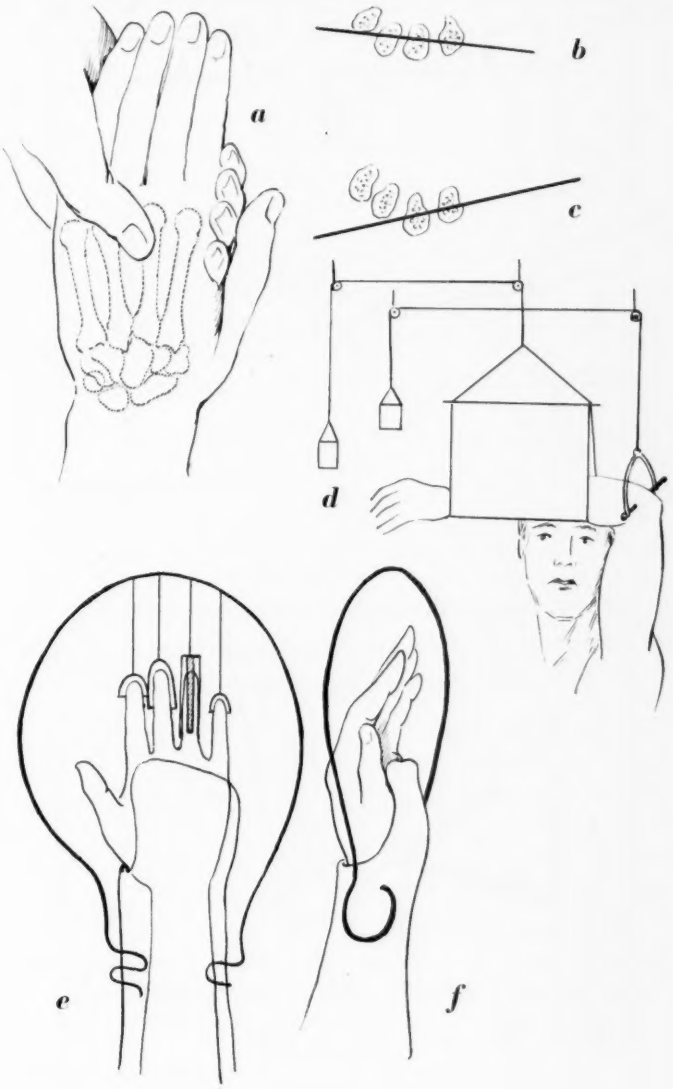
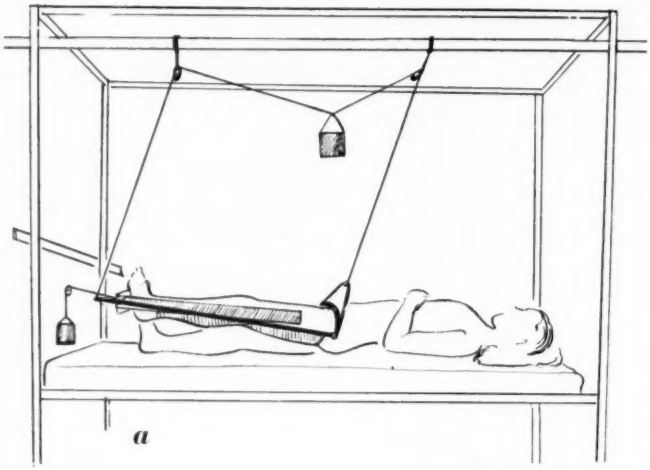
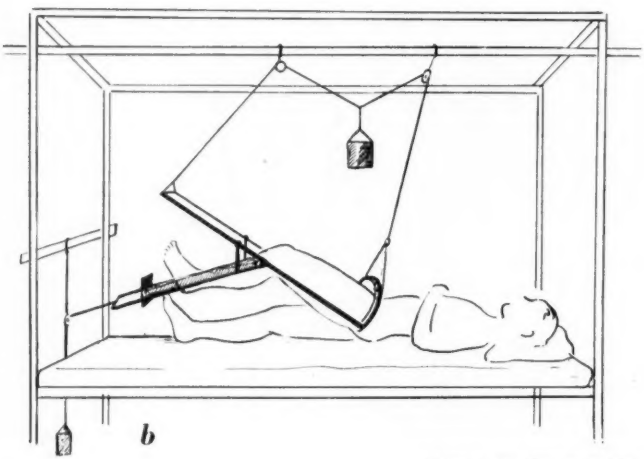


FIGURE 1

SUSPENSION OF LEG AND



WITH KNEE STRAIGHT



WITH KNEE FLEXED

FIGURE 2

APPLICATION OF TRACTION

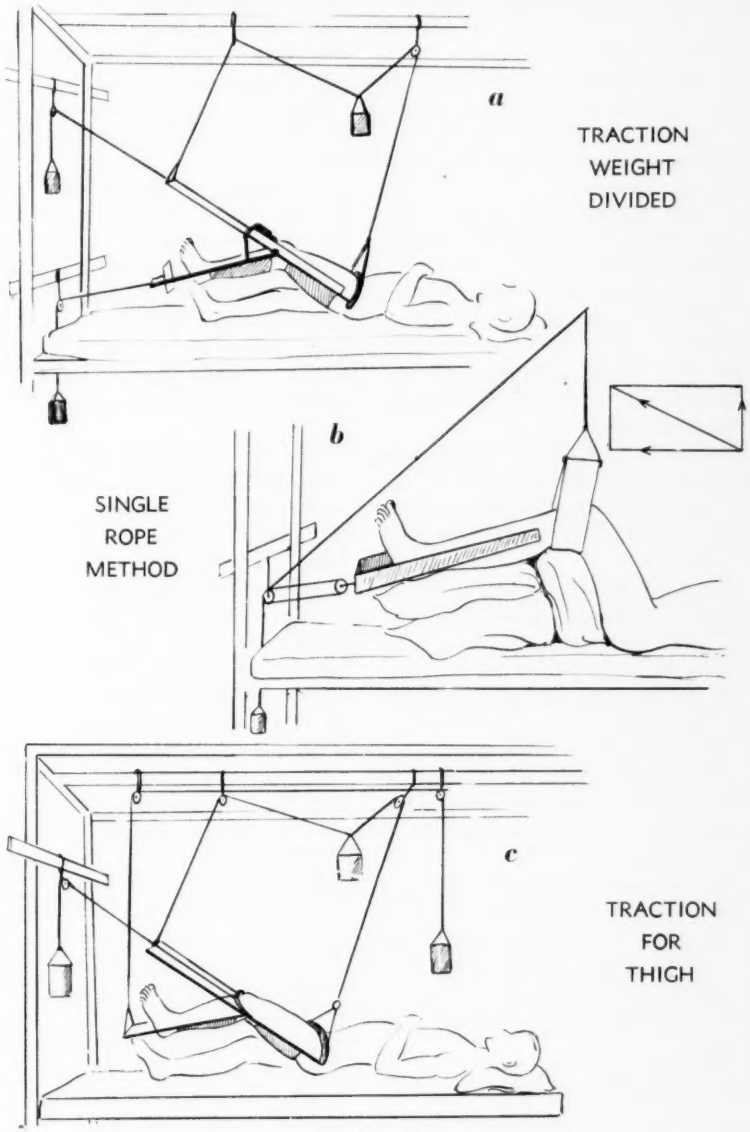


FIGURE 3

be properly adjusted between the two ends of the half-ring splint, which requires greater force for the upper than for the lower end.

► The weight for knee motion should be within easy reach of the patient, and the trough for the leg should be shallow enough to avoid peroneal pressure.

► The skeletal pin should rest against the bar of the splint instead of pulling on the skin.

► The inner half of the ring should not press on the groin or perineum.

► The upper support for the splint should be adjusted to allow proper rotation.

Efficacy of traction and comfort of the patient will be increased if the injured limb is suspended by weights and pulleys different from those used for traction.

Traction applied in balanced suspension eliminates encircling bandages which interfere with blood flow, permits early motion of the adjacent joints, allows use of heat and massage, gives free access to wounds, and lessens the liability of bedsores.

Chief disadvantages of this method of management are that bed rest is usually required and the patient is not transportable.

The amount of traction required varies with the lapse of time since the injury. With longer time, more force is necessary. Skeletal traction is a very powerful force and excessive traction is too often applied and for too long a time.

Overpull, with separation of fragments, is one of the main causes of delayed union or nonunion. Heavy weight may be applied only until reduction is effected, otherwise results may be unsatisfactory.

Insertion of the pins calls for the same aseptic precautions that are essential in any operation.

The pin that initiates soft tissue movement sooner or later engenders infection.

A Hodgen or Keller-Blake splint may be used for the lower extremity. The thigh and leg rest in a felt-lined canvas or flannel sling attached to two lateral bars. When a half-ring splint is employed, the ring should be in front and rotated as necessary unless counter pressure against the tuber ischii is deemed advisable (Fig. 2*a*).

The upper margin of the canvas sling should be attached to the ring so that the thigh is always supported. If the band under the fibula is too loose, pressure over the peroneal nerve may cause paralysis.

Figure 2*b* shows a method of suspension with the knee flexed. The force is applied by adhesive traction on the lower leg, which is supported by a Pearson attachment.

Figure 3*a* demonstrates how traction weight may be divided between the upper and lower leg by addition of another weight.

Quite a different system, Russell's method, illustrated in Figure 3*b*, permits the entire traction and suspension to be accomplished with a single rope, but constant attention is necessary to maintain support of the thigh at all times.

Skeletal traction for the thigh is shown in Figure 3*c*. The weight controlling knee motion is within reach of the patient and the Pearson attachment is not locked.

Roseola Infantum

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FEVER in infancy is one of the most common and difficult problems confronting the general practitioner and pediatrician.

Probably the most frequent febrile exanthem in children is roseola infantum, a disease with a relatively asymptomatic course of three to five days followed by appearance of a morbilliform eruption.

Although William Berenberg, M.D., Stanley Wright, M.D., and Charles A. Janeway, M.D., believe the disease is an almost universal infection for children under five years of age, few patients are seriously ill or hospitalized. Consequently, medical students do not see many cases and physicians generally are unfamiliar with the condition.

Fully 95% of the patients are children between six months and three years of age. During the first months of life the infant may be protected by transplacental passive immunization.

Rarity of roseola infantum after the third year, in view of susceptibility of occasional older patients, raises the possibility that almost all individuals may have the disease before the age of three, probably from contact with adult carriers, and often in an atypical modified form that defies detection.

An unknown virus is probably responsible. Incubation period is ten to fifteen days, and a single attack confers permanent immunity. Prognosis is excellent, although many sudden deaths of infancy may eventually be proved to be unusually severe, unrecognized forms of roseola.

Complications are rare but can be serious and include convulsions, encephalitis, and hemiplegia.

Infection may develop at any time. Peak incidence is in the spring and fall. Onset of fever is abrupt with the child apparently quite well, active, and alert. In a day or two rose-pink macules appear. The rash does not itch and fades completely without desquamation in two to forty-eight hours.

The temperature is often 103° to 105° when first noted. Fever continues three to nine days. Pulse and respiratory rates increase with temperature. On the first day leukocytosis, by the second or third day, leukopenia, neutropenia, and relative lymphocytosis appear.

Throat and tonsils may be slightly inflamed. Under good light, reddish pinpoint lymphoid elevations are

* Roseola infantum (exanthem subitum). New England J. Med. 241:253-259, 1949.

seen about the uvula and soft palate. Suboccipital and posterior cervical lymph nodes may be palpable by the second or third day of fever and may remain so for several weeks. In 1 of 4 cases, slight catarrhal otitis media develops.

Treatment is purely symptomatic. Sulfonamides and antibiotics are of no value. Rest should be provided and fluids given freely. Aspirin may be prescribed, and if fever is exceptionally high, phenobarbital is administered to prevent convulsions.

Bronchiectasis in Childhood

C. ELAINE FIELD, M.D., LONDON*

IRREVERSIBLE bronchiectasis can be avoided by careful management of upper respiratory tract disease in childhood.

When bronchial dilatation is established, involved portions of the lung should be removed if enough healthy tissue remains for adequate function. In the experience of C. Elaine Field, M.D., of University College Hospital, London, medical therapy often arrests but seldom reverses the progress of disease. Surgical treatment, on the other hand, may be curative in half the cases.

Results of treatment were observd in 202 children for periods up to ten years. Bilateral lobectomy was successful in 10 instances. Complete resection of affected tissue was curative in 54% of cases; medical treatment in 12%.

During recovery from pneumonia, pertussis, and other respiratory infections the chest should be examined repeatedly. Asthma with bronchitis and so-called chronic bronchitis may actually comprise early bronchiectasis. If a cough persists, postural drainage and breathing exercises should be employed.

When constant cough and dilatation have continued for a year or more, surgical treatment may be necessary. In extensive cases, grossly diseased parts may be excised and symptoms relieved by other measures.

Regardless of slightness or severity of manifestations, operation should be done in all cases not too advanced for complete anatomic and symptomatic cure. If possible, segments are removed rather than entire lobes, and half the pulmonary tissue is saved.

In a child, the remaining bronchi grow and lungs occupy almost the same area as before. Much more function returns to children after operation than to adults.

The most effective chemotherapy combines penicillin with streptomycin.

* Bronchiectasis in childhood. Pediatrics 4:355-372, 1949.

Tonsils, Adenoids, and Allergy

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REGROWTH of adenoid and tonsillar tissue after resection is usually due to unsuspected allergy.

Before tonsillectomy and adenoidectomy are undertaken for nasopharyngeal disorders, an allergic source should be sought.

Norman W. Clein, M.D., believes that operation may fail in presence of any of the following symptoms:

► Constantly running nose more troublesome at night and on arising

► Repeated colds and chronic cough, also worse at night

► So-called chronic sinusitis with or without migraine

► Persistence of complaints after operation and return of hypertrophic tissue.

In about half the allergic cases, pathologic tissue shrinks or atrophies during treatment and no surgery is required. In the remainder, surgery may be done, since postoperative hypertrophy will be negligible and return of the original symptoms less likely.

Nasopharyngeal allergy is manifest in children by symptoms of the following two types:

1 One cold after another, usually without fever, seasonal or perennial. Mouth kept open most of the time, especially at night. Habitual snoring. Sniffling and nose blowing, notably early in the morning.

2 Colds accompanied by hacking or clearing of the throat. Deep, hard, dry cough, aggravated by exercise or fatigue and more frequent at night. Wheezing and difficult breathing. Attacks of croup, sometimes accompanied by respiratory infection. Low-grade fever occasionally continuing for months.

An excess of eosinophils in repeated nasal smears is pathognomonic of the allergic cold.

After unsuccessful operation, lymphoid tissue returns more often to the nose than to the throat, and the most common complaint is mouth breathing. Anterior turbinates may be swollen or normal, but invisible postnasal edema is often shown by blowing on one side. Unlike stenosis from a large adenoid mass, allergic congestion subsides at intervals.

Tonsillar hyperplasia may appear as early as five months after resection. Reddish swollen lymphoid areas resembling granulation tissue may be observed under the anterior pillar or in the middle of a fossa. Lateral pharyngeal walls often contain scattered, round, raised nodules of pinhead to pea size.

Operation during the pollen season may aggravate hay fever or initiate asthma.

Postnasal lymphoid hyperplasia may be reduced by application of radium.

* Allergy and the tonsil problem in children. Ann. Allergy 7:329-333, 1949.

Development of Vision in Childhood

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LIKE speech, vision develops slowly and passes through many contrasting stages. Since all are closely related to posture, manual skills, motor habits, intelligence, and personality, one atypical trait often points to others.

Arnold Gesell, M.D., advises systematic preschool examinations. Brain lesions as well as ocular defects may be revealed and future problems forecast. At all ages both educational and corrective measures should be geared to the child's actual capacity.

The relation of sight to behavior was investigated from premature birth to the tenth year in the home, guidance nursery, and school. About 50 children were observed at each of twenty age levels.

When the newborn baby sees something of interest, body activity tends to subside. A full-term infant begins to notice a near-by, approaching object on the first day of life, sustains fixation in the first week, and regards more distant objects in a month. He will notice a pellet 7 mm. in diameter twenty weeks sooner than he can pick it up with his fingers.

Seeing ability is shown by ocular and other attitudes. Excessive hand regard beyond the age of twelve weeks may signify myopia, while delayed hand regard may indicate mental deficiency or atypical spatial manipulation. Unusual eye-hand patterns are sometimes harbingers of speech defects and reading disability. A clumsy hand or foot at the age of two and a half years may foretell strabismus a year or two later.

The preschool child's use of cup, spoon, crayon, paints, and picture books is significant. Too much or too little staring, caution, or withdrawal from companions may be due to visual rather than emotional difficulty.

In the school years, changing function causes many problems. Sustained attention may be demanded of a pupil in the phase of shifting activity, or ability rated poor because instruction is too advanced. Premature reading and writing are to be avoided. Frequently, inadequate vision requires improved teaching rather than treatment.

Sight operates in three basic fields: skeletal, visceral, and cortical. The skeletal component seeks and holds a visual image, the visceral component discriminates and defines, while cortical activity unifies and interprets.

All three functions vary with ad-

* The developmental aspect of child vision. J. Pediat. 35:310-316, 1949.

vancing maturity. After the age of five years new abilities appear, not always in balanced or well-timed relation. At seven years the visceral-skeletal linkage is relatively tight, at eight more facile, and at nine years again consolidated.

Visual ability also depends on coordination of the two eyes and right versus left dominance; reach to different planes of regard; scope of central and peripheral view; and drift, including span of ocular ductions, preferred zones of regard, accommodation, and dominant direction.

The retinoscope shows a close relation between visual function and total activity. As the eye gropes, grasps, and manipulates, the reflected beam of light varies in brightness, motion, direction, speed, and color. Light intensifies when the infant seizes a target.

Not only refraction and fusion but the child's organization of visual equipment should be considered in overcoming disability. Partial correction may call forth the child's best resources when full correction would supply a hampering crutch. Training and therapeutic regimens should be wisely timed in short, interesting sessions and perfectionist aims should be avoided.

Histamine Therapy with Electric Shock

A. M. SACKLER, M.D., M. D. SACKLER, M.D., AND R. R. SACKLER, M.D.*

PRELIMINARY course of histamine injections may double the number of schizophrenic, manic depressive, and involutional psychotic patients leaving mental hospitals after electric convulsive therapy. A. M. Sackler, M.D., M. D. Sackler, M.D., and R. R. Sackler, M.D., of the Creedmoor State Hospital, New York City, inject histamine base in saline solution subcutaneously, intramuscularly, or intravenously in doses of 1 to 3 mg. once or twice daily for a few days to several weeks.

A group of 25 women refractory to these injections received electrotherapy. Nearly half the subjects improved and 16% were able to go home. Of those receiving histamine or electric convulsive therapy alone, about one-fourth were benefited and one-eighth discharged.

Histamine is most effective when administered early. The majority of women improved by drug or combined treatment had been in the hospital not more than six months. Of the short-term group, 31% were able to return home after combined therapy, 21% after histamine only, and 14% after shock.

* Nonconvulsive biochemotherapy with histamine and electric convulsive therapy. J. Nerv. & Ment. Dis. 110:185-197, 1949.

Office Treatment of Syphilis

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Columbia University and Department of Health, New York City

In private practice the number of patients treated for syphilis is relatively small. Trial-and-error schedules used in large clinics are not applicable since the practitioner desires to give sufficient medication to insure the best possible results for each individual.

Theodore Rosenthal, M.D., outlines for the various forms of syphilis the following treatment, which, in the light of present knowledge, approximates minimal therapy but assures optimum results. Although penicillin is the principal drug employed, the addition of arsenoxide and bismuth has genuine synergistic value.

Primary and secondary syphilis and latent and benign late syphilis are best treated as follows: 6,000,000 units of procaine penicillin G is administered intramuscularly in doses of 600,000 units each day for ten days except Sundays. Then twenty injections of mapharsen are given at the rate of two injections per week for ten weeks. One injection of bismuth is given each week for ten weeks either concurrent with or following the course of mapharsen.

Thereafter, titrated serologic tests for syphilis must be done monthly for one year and patients carefully observed.

Spinal fluid examination is performed before therapy in late syphilis and within twelve months after treatment in either primary or secondary syphilis.

The entire course is repeated for either a clinical or serologic therapeutic failure.

If a patient with neurosyphilis can be ambulatory, 9,000,000 units of procaine penicillin G in doses of 600,000 units intramuscularly every other day for fifteen injections is the treatment suggested.

Consultation with a neurologist is desirable for patients with neurosyphilis requiring hospitalization.

Cardiovascular syphilis must be treated cautiously, beginning with heavy metals for six to eight weeks. At least 6,000,000 units of penicillin in relatively small divided doses is then given over a period of fifteen or more days.

Therapy for ocular syphilis should always be planned with an ophthalmologist.

A serologic pattern may not be established for ten to twelve weeks in the newborn. For congenital syphilis penicillin G is administered in aqueous solution if the patient is less than two years of age.

A total amount of from 100,000 to 400,000 units per kilogram of body weight is given in divided doses throughout the day and night for eight to fifteen days.

* Treatment of syphilis in private practice. New York Med. 5:16-18, 34, 37, 1949.

Older children may receive procaine penicillin G in doses of 6,000 to 12,000 units per kilogram of body weight daily for two to three weeks.

Syphilis is almost certainly prevented in the offspring if the syphilitic pregnant woman receives adequate penicillin therapy.

A pregnant woman with syphilis is given 600,000 units of procaine penicillin G daily for ten days, beginning immediately after the diagnosis is made, regardless of the stage of gestation, even as late as when admitted to the hospital for delivery. Monthly titers are determined until delivery. The patient probably should be given penicillin during each successive pregnancy even when the infection is apparently cured.

Penicillin-intolerant patients require prolonged courses of mapharsen and bismuth, with a minimum of forty injections of mapharsen and sixty of bismuth. Urine should be examined periodically and attention given to optic or auditory nerve involvement, severe headaches, dermatitis, jaundice, enlargement of the liver, or acholic stools.

SARCOIDOSIS apparently is not significantly affected by vitamin D_2 therapy. Remissions appear in less than a year with or without treatment in 50% of cases, finds Carl T. Nelson, M.D., of Columbia University, New York City, after a twelve-month study of 16 patients with the disease, 8 of whom were given large doses of calciferol and 8 of whom were untreated. Although recovery was more rapid in the patients given calciferol, the difference was not great. Vitamin D_2 dosage was 120,000 units daily in a mixture of equal parts of ethyl alcohol and propylene glycol unless improvement was noted, in which event the dosage was halved. Previous reports on the efficacy of calciferol for sarcoidosis have concerned white patients. The fact that 15 of the 16 patients were Negroes may account for the disparity in results.

J. Invest. Dermat. 13:81-84, 1949.

DISSEMINATED NEURODERMATITIS may be alleviated by topical application of Thephorin. The antihistaminic drug apparently is able to penetrate skin rapidly, since relief from itching usually starts within fifteen minutes, find Wilfred E. Wooldridge, M.D., and Herbert L. Joseph, M.D. Effects last two to three hours or longer. Nearly all of 23 patients in the Barnard Free Skin and Cancer Hospital and Washington University, St. Louis, were subjectively relieved by the ointment although the eruptions of only 2 subjects were completely cleared. A single case of induced sensitivity occurred, but no constitutional reactions were noted. Results were less successful with circumscribed neurodermatitis.

Arch. Dermat. & Syph. 60:390-403, 1949.

The Eye in General Practice

A. J. BALLANTYNE, M.D.*
University of Glasgow, Scotland

THE family physician is often confronted with ocular problems such as sudden loss of sight, uveitis from infectious disease, and the retinal vascular changes of essential hypertension, diabetes, and pregnancy.

A. J. Ballantyne, M.D., lists a number of helpful diagnostic and prognostic clues.

LOSS OF SIGHT

Few symptoms cover a larger field of possible causes than sudden failure of vision.

Detachment of the retina is frequently responsible when sight of one eye is lost. At whatever point the retina separates, fluid tends to settle in the lower part of the eye, throwing a dark curtain or shadow over the upper part of the visual field. Test finger movements may show the defect before ophthalmoscopic examination is made.

Sudden darkening of the whole field of vision in an eye most often results from hemorrhage into the vitreous, ranging in severity from a reddish tinge to obliteration of light. Repeated minor hemorrhages with intervals of apparent recovery are sometimes caused by tuberculous changes. In many cases blood clots organize, the retina is detached, and the eye is lost.

Complete obstruction of a central retinal vessel causes practically total blindness. With arterial embolism the entire retina rapidly becomes ischemic and, since viability is destroyed in a few minutes, rarely regains function. Occasionally the clot is moved or absorbed.

Venous obstruction is productive of edema with multiple large hemorrhages throughout the retina and usually abolishes useful sight.

Amblyopia from arterial spasm tends to be sudden, short, recurrent, and sooner or later bilateral. With arteriosclerosis and hypertension, a fatal cerebral seizure may ensue.

Retrobulbar optic neuritis causes a central scotoma often preceded or followed by transient diplopia. In some cases eye movements and pressure on the eyeball are painful. Recovery is the rule.

Sudden binocular loss of sight is ordinarily due to a toxin. Amblyopia or amaurosis during pregnancy may be a serious forewarning of eclampsia or, less often, a consequence of hyperemesis gravidarum with retrobulbar neuritis. In the latter case, large doses of vitamins B_1 and C may be helpful.

Sudden temporary dimness of vision with early diabetes is due to change in the crystalline lens. The eyes become myopic but, with system-

* The eye in general medicine. Practitioner 163:173-181, 1949.

ic treatment, revert to the original refractive state.

Quinine blindness is rare and apparently due to idiosyncrasy. Wide inactive pupils, deafness, and impaired consciousness may be observed. Although the retina becomes ischemic, central and incomplete peripheral vision returns.

INFLAMMATORY OCULAR LESIONS

Iritis, cyclitis, and choroiditis may occur with the exanthems, focal sepsis, syphilis, and other systemic diseases. Subacute uveitis may be the outstanding manifestation of Boeck's sarcoidosis or of spondylarthritis ankylopoietica. When the cause of uveitis is not found, antituberculous measures are often effective.

Congenital cataract and related deformities may result from maternal infection with mumps, measles, chickenpox, and scarlet fever as well as rubella in early pregnancy.

HYPERTENSION

In the first stage of essential hypertension, retinal vessels are well filled and tortuous, with good color and copper high lights. Veins are slightly compressed at arterial crossings. Later the arteries narrow and the veins become more obviously dented.

Superficial striate or spindle-shaped hemorrhages occur about the disk and eventually bleeding involves all retinal layers. Exudates appear as small discrete points which coalesce, scattered woolly white patches, or diffuse serofibrinous infiltration. A macular star is seen in the fully developed stage. Arteriosclerosis may develop before or after onset of malignant hypertension but is usually prominent in the final stage.

In most cases the prognosis of hypertension corresponds to degree of eyeground change. Early retinal lesions without hemorrhages or exudates may disappear with treatment and occasionally severe changes are reversed by sympathectomy.

DIABETES

Diabetes mellitus first produces capillary aneurysms seen as minute red dots near the macula. Round or polygonal hemorrhages then appear in deep retinal layers, and punctate exudates form increasingly larger patches with a waxy yellowish surface.

Retinal veins become full and tortuous, with kinks, loops, and fatty infiltration of walls. Networks of new vessels develop. Retinopathy is not related to severity of diabetes. Eyeground lesions steadily progress and may cause blindness in a reasonably healthy patient.

PREGNANCY

Ophthalmoscopic examination during pregnancy may show vessel changes of incipient hypertension, arteriosclerosis, nephrosclerosis, or diabetes. Early fundus changes of hyperemesis gravidarum consist of hemorrhages and papilledema.

Preeclamptic toxemia with profound visual loss may produce only diffuse narrowing of retinal arteries and arteriovenous crossings with slight edema of the disk and retina. If fundal lesions do not improve after two weeks of general therapy, pregnancy should be terminated at once.

The Eye in General Practice

A. J. BALLANTYNE, M.D.*
University of Glasgow, Scotland

THE family physician is often confronted with ocular problems such as sudden loss of sight, uveitis from infectious disease, and the retinal vascular changes of essential hypertension, diabetes, and pregnancy.

A. J. Ballantyne, M.D., lists a number of helpful diagnostic and prognostic clues.

LOSS OF SIGHT

Few symptoms cover a larger field of possible causes than sudden failure of vision.

Detachment of the retina is frequently responsible when sight of one eye is lost. At whatever point the retina separates, fluid tends to settle in the lower part of the eye, throwing a dark curtain or shadow over the upper part of the visual field. Test finger movements may show the defect before ophthalmoscopic examination is made.

Sudden darkening of the whole field of vision in an eye most often results from hemorrhage into the vitreous, ranging in severity from a reddish tinge to obliteration of light. Repeated minor hemorrhages with intervals of apparent recovery are sometimes caused by tuberculous changes. In many cases blood clots organize, the retina is detached, and the eye is lost.

Complete obstruction of a central retinal vessel causes practically total blindness. With arterial embolism the entire retina rapidly becomes ischemic and, since viability is destroyed in a few minutes, rarely regains function. Occasionally the clot is moved or absorbed.

Venous obstruction is productive of edema with multiple large hemorrhages throughout the retina and usually abolishes useful sight.

Amblyopia from arterial spasm tends to be sudden, short, recurrent, and sooner or later bilateral. With arteriosclerosis and hypertension, a fatal cerebral seizure may ensue.

Retrobulbar optic neuritis causes a central scotoma often preceded or followed by transient diplopia. In some cases eye movements and pressure on the eyeball are painful. Recovery is the rule.

Sudden binocular loss of sight is ordinarily due to a toxin. Amblyopia or amaurosis during pregnancy may be a serious forewarning of eclampsia or, less often, a consequence of hyperemesis gravidarum with retrobulbar neuritis. In the latter case, large doses of vitamins B_1 and C may be helpful.

Sudden temporary dimness of vision with early diabetes is due to change in the crystalline lens. The eyes become myopic but, with system-

* The eye in general medicine. Practitioner 163:173-181, 1949.

ic treatment, revert to the original refractive state.

Quinine blindness is rare and apparently due to idiosyncrasy. Wide inactive pupils, deafness, and impaired consciousness may be observed. Although the retina becomes ischemic, central and incomplete peripheral vision returns.

INFLAMMATORY OCULAR LESIONS

Iritis, cyclitis, and choroiditis may occur with the exanthems, focal sepsis, syphilis, and other systemic diseases. Subacute uveitis may be the outstanding manifestation of Boeck's sarcoidosis or of spondylarthritis ankylopoietica. When the cause of uveitis is not found, antituberculous measures are often effective.

Congenital cataract and related deformities may result from maternal infection with mumps, measles, chickenpox, and scarlet fever as well as rubella in early pregnancy.

HYPERTENSION

In the first stage of essential hypertension, retinal vessels are well filled and tortuous, with good color and copper high lights. Veins are slightly compressed at arterial crossings. Later the arteries narrow and the veins become more obviously dented.

Superficial striate or spindle-shaped hemorrhages occur about the disk and eventually bleeding involves all retinal layers. Exudates appear as small discrete points which coalesce, scattered woolly white patches, or diffuse serofibrinous infiltration. A macular star is seen in the fully developed stage. Arteriosclerosis may develop before or after onset of malignant hypertension but is usually prominent in the final stage.

In most cases the prognosis of hypertension corresponds to degree of eyeground change. Early retinal lesions without hemorrhages or exudates may disappear with treatment and occasionally severe changes are reversed by sympathectomy.

DIABETES

Diabetes mellitus first produces capillary aneurysms seen as minute red dots near the macula. Round or polygonal hemorrhages then appear in deep retinal layers, and punctate exudates form increasingly larger patches with a waxy yellowish surface.

Retinal veins become full and tortuous, with kinks, loops, and fatty infiltration of walls. Networks of new vessels develop. Retinopathy is not related to severity of diabetes. Eyeground lesions steadily progress and may cause blindness in a reasonably healthy patient.

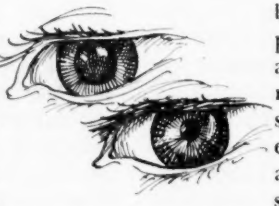
PREGNANCY

Ophthalmoscopic examination during pregnancy may show vessel changes of incipient hypertension, arteriosclerosis, nephrosclerosis, or diabetes. Early fundus changes of hyperemesis gravidarum consist of hemorrhages and papilledema.

Preeclamptic toxemia with profound visual loss may produce only diffuse narrowing of retinal arteries and arteriovenous crossings with slight edema of the disk and retina. If fundal lesions do not improve after two weeks of general therapy, pregnancy should be terminated at once.

Surgery for Primary Glaucoma

CONRAD BERENS, M.D., L. BENJAMIN SHEPPARD, M.D.,
ARTHUR B. DUEL, JR., M.D., AND LOUIS J. GIRARD, M.D.*
New York City



SELECTION of the best operation for primary glaucoma is difficult because the disease has no universally recognized classification. The principal types of glaucoma, narrow and wide angle, should be differentiated, but even after careful study the two are not always distinguishable.

Conrad Berens, M.D., L. Benjamin Sheppard, M.D., Arthur B. Duel, Jr., M.D., and Louis J. Girard, M.D., observe, however, that different technics have been successful in treating glaucoma and that choice of treatment continues to be empiric, depending much on the surgeon's preference and ability.

Aspects of each case, including base pressure, angle width, peripheral anterior synechiae, chronic infection, and atrophy of the iris and conjunctiva, must be taken into consideration before choice of operation is made.

For acute primary glaucoma, operation is ordinarily indicated if medical therapy is ineffective after twelve hours' trial. Delay allows peripheral anterior synechiae to form.

The best technic is usually a basal iridectomy, especially when surgery is performed early and the angle is narrow. The same procedure may also be advisable with chronic primary glaucoma if the angle is narrow, the iris not atrophic, base pressure low, and few peripheral anterior synechiae are evident. Even when some of these conditions are unfavorable, the operation may succeed in skilled hands.

Basal iridectomy, even when combined with early and repeated massage, sometimes fails to control tension, especially when the anterior chamber is deep, previous medical therapy has not reduced tension, and anterior synechiae are seen or suspected. In such cases iridocorneosclerectomy may be done.

For wide-angle glaucoma, an external or internal filtering operation should be chosen. Cyclodialysis with the introduction of air is used if the base pressure is low and the fields strongly contrasted. When pressure is over 40 mm. Hg (Schiötz), iridocorneosclerectomy is advisable; the iris pillars are incarcerated in the wound if pressure is above 50 mm.

With a rapidly developing cataract, complete iridectomy is performed.

Although iridencleisis is more effective than iridectomy in the later stages of acute primary glaucoma and has been used successfully in severe chron-

* The surgery of primary glaucoma. South. M. J. 42:731-738, 1949.

ic cases, the operation may provoke sympathetic ophthalmitis.

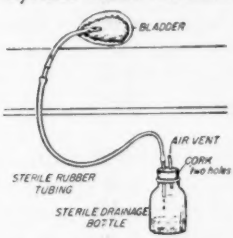
Not enough is known about cyclo-electrolysis to recommend the operation as a primary procedure, but the technic may be used when other operations have failed to control tension and is the best procedure for Negro patients, in whom filtering operations frequently fail. If tension is high after operation in these cases, aspiration or electroparacentesis is used.

Gun-barrel fields are probably a contraindication to ophthalmologic operation.

Sterile Urinary Drainage

WESTON T. BUDDINGTON, M.D., AND ROGER C. GRAVES, M.D.*

MECHANICAL introduction of bacteria is the usual cause for urinary infection in patients subjected to prolonged catheter drainage. Cystitis from urethral or suprapubic procedures may be much reduced or completely averted by consistently sterile technic.



Weston T. Buddington, M.D., and Roger C. Graves, M.D., of Tufts College, Boston, prevent reflux of contaminated urine with a special drainage bottle (see illustration).

The stopper has two holes for a connecting tube and an air vent. Bottle, cork, rubber tubing, and glass connections are autoclaved as a unit and replaced every other day.

The sterile drainage system has two advantages, both of which prevent retrograde extension of bacteria along the catheter:

1] When the container is raised above bladder level, as often done by nurse and patient, reverse siphonage of bottle contents is practically impossible.

2] If backflow does occur, the pool of urine is sterile and does not contaminate the lower end of the tubing.

In obtaining specimens for culture, a section of drainage tube is prepared with tincture of iodine, and urine is aspirated with needle and syringe.

Antibiotic treatment is continued night and day with sulfadiazine, penicillin, methenamine with sodium acid phosphate, or other drugs. Streptomycin is given for severe infection with gram-negative bacilli, especially *Proteus* and *Pseudomonas,* and just before discharge from the hospital.

* Management of catheter drainage. J. Urol. 62:387-393, 1949.

Cause and Therapy of Pelvic Myalgia

NORBORNE B. POWELL, M.D.*
Baylor University, Houston

PAINFUL spasm of the piriformis muscle group may arise from posterior urethritis or from anorectal and orthopedic disorders. As a result, bizarre unilateral or bilateral symptoms may appear in one or more regions of the pelvis, hip, or thigh.

The principal causes of pelvic myalgia are chronic prostatitis in males and the urethral syndrome in females. Norborne B. Powell, M.D., diagnoses the condition by rectal or vaginal palpation. Tense muscles can usually be relaxed by massage of the pelvic floor.

Chronic inflammation of the urethra, prostate, or rectum is accompanied by lymph stasis along the posterior pelvic floor, which produces edema of the common peroneal nerve.

The piriformis muscle, which is usually pierced by the nerve, may then tighten, compressing the sciatic nerve between the piriformis and superior gemellus. Consequent slight pressure on sensory fibers results in pelvic myalgia. Pain from skeletal or postural defects is probably due to mechanical stretching of muscles.

The piriformis, inferior and superior gemelli, obturator internus, gluteus medius, levator ani, and coccygeus may be affected singly or in groups. Tension produces symptoms in areas supplied by the fourth and fifth lumbar nerves and the first and second sacral nerves.

Pain, ache, or numbness may occur about the hip joint, coccyx, or both; indefinite ache down the sciatic area; discomfort or ache in one or both groins; vague distress or sense of weight in the vagina, rectum or deep pelvis of a woman, in the perineum or rectum of a man.

When a finger is inserted into the rectum or vagina a tender muscular ridge is felt from the coccyx to the medial surface of the hip joint. Spasm confined to one side is particularly obvious.

Although urethral therapy would eventually relieve the spastic condition, cure is hastened by gentle massage. The patient should be warned that in 10% of cases symptoms temporarily become worse during the course of treatment.

The finger is placed in vagina or rectum and swept laterally from coccyx to acetabulum and back several times. When the entire surface of the muscular ridge has been covered, direction is changed. Stroking continues in a plane perpendicular to the first maneuver, gradually working toward the acetabulum.

Massage seldom produces more than slight discomfort, but if tension is extreme the lightest touch may

* Pelvic myalgia: a complication of posterior urethritis in males and females. J. Urol. 62:245-249. 1949.

cause excruciating pain. After a momentary pause, however, treatment can generally be resumed.

As a rule, myalgia partly or completely disappears for two to four days after the first treatment. Exacerbations are checked by aspirin, codeine, and external heat. The massage should be repeated at intervals until symptoms are gone.

Bell's Palsy

JEROME A. HILGER, M.D.*

FOR want of an etiologic description, peripheral facial paralysis not caused by trauma, infection, or neoplasm retains the designation of Bell's palsy.

The condition is an ischemic neuritis which results from segmental arteriolar spasm, observes Jerome A. Hilger, M.D., of St. Paul. Edema of the nerve may occur as a secondary phenomenon. The tendency to arteriolar constriction is probably on the basis of an inherited potential imbalance of the autonomic nervous system.

Unusual chilling of the side of the face has been cited as a precipitating cause of the paralysis in many cases. Severe emotional upset or shock may be the precipitating factor. A familial tendency exists.

Onset is usually sudden. Pain about the ear is not uncommon in the first forty-eight hours. Adults are the most frequently afflicted. The paralysis may be partial or complete. The only prognostic sign is the completeness of paralysis or the loss of faradism. Hyperacusis and loss of taste are common in early stages, but these sensory disturbances usually disappear even if the paralysis persists. This is due to collateral arterial supply to the proximal portion of the nerve trunk.

Principal fault in therapy today is the neglect of nonsurgical measures. Recovery occurs spontaneously in about 85% of cases but can be greatly facilitated by active therapeutic measures.

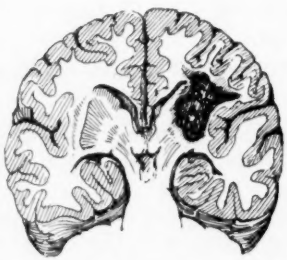
Therapy should be directed toward relief of the vasospasm. Immediate use of vasodilators, such as nicotinic acid, intravenous histamine, or papaverine, or sympathetic paralyzers, such as ergotamine tartrate or tetraethylammonium chloride, may be effective. Cervical sympathetic block is sometimes valuable.

Surgical decompression of the edematous nerve trunk may be necessary in some cases, but the timing of the procedure has not been definitely determined. Waiting until fibrosis replaces necrosis in the nerve trunk is certainly unwise; however, fibrosis is infrequent in nerves with paresis of less than six months' duration. Muscle reactivity may be retained through electrical stimulation, support, and massage.

* The nature of Bell's palsy. Laryngoscope 59:228-235, 1949.

Cerebral Apoplexy

HARRY M. ZIMMERMAN, M.D.*
Columbia University, New York City



DEATHS from brain hemorrhage are often prevented and disabling sequelae reduced by evacuation of blood. Before exploratory craniotomy is undertaken, however, cerebral hemorrhage must be differentiated from infarct, the lesion accurately located, and pathogenesis understood.

Both types of cerebrovascular accident were investigated by Harry M. Zimmerman, M.D. Brains were examined post mortem in 182 consecutive cases; of these, 107 revealed spontaneous hemorrhages, and 75 had infarcts. Effects of 175 nonfatal cerebrovascular lesions were also reviewed; here the two conditions were about evenly divided.

Brain hemorrhage occurs with equal frequency in men and women, and incidence of fatal and nonfatal lesions reaches a peak in the sixth decade of life. Most deaths occur during the first attack, within five weeks of onset.

The cause of bleeding is practically always hypertension, with heart and kidney involvement in the majority of instances.

The symptoms of hemorrhagic stroke, in order of frequency, are sudden loss of consciousness, paralysis, a fall, vomiting, headache, vertigo, convulsions, and weakness.

The delayed effects are unconsciousness, reflex changes, paralysis, pupillary or fundic abnormalities, a positive Babinski sign, spasticity, and vomiting.

As a rule, spinal fluid contains blood, and pressure is increased.

Infarction of the brain is 2 or 3 times more common in men than in women. Peak incidence is at least ten years later than with brain hemorrhage. Prospects of survival are better than with bleeding; fewer fatalities occur in the first attack and a larger number three years or more after onset of symptoms.

Hypertension is relatively infrequent, developing before death in less than half the cases, often without cardiovascular renal disease.

Infarction is first shown by a generalized paralysis, unconsciousness, mental disturbance, a fall, weakness, or dysarthria. Most common during the subsequent illness are paralysis, unconsciousness, reflex changes, mental aberration, dysarthria, pupillary disorders, a positive Babinski sign, and nuchal rigidity.

Spinal fluid seldom contains blood, and pressure is generally normal.

* Cerebral apoplexy: mechanism and differential diagnosis. New York State J. Med. 49:2153-2157, 1949.

Spontaneous cerebral hemorrhage occurs in right and left cerebral hemispheres with equal frequency. The site in 38% of cases is supplied by the lenticulostriate artery or branches. Apart from basal ganglia, affected regions may include the frontal lobes, cerebellum, calcarine areas, ventricular system, occipital poles, pons, and occasionally the centrum ovale of all lobes in one hemisphere.

About three-fourths of hemorrhages are due to rupture of miliary dissecting aneurysms in atherosclerotic cerebral arterioles. From intramural to massive flow is but a step. As blood spreads into nervous tissue, neighboring capillaries and venules are torn and add other hemorrhages. The tide may reach Virchow-Robin spaces of larger vessels and mix with cerebrospinal fluid or burst into the subarachnoid region through disrupted gray matter. The ventricles may be flooded by a break in the basal ganglia.

The hematoma apparently reaches maximum size in minutes or at most a few hours, then forms a permanent cavity by destruction or compression of adjacent zones. After remaining liquid for several days, blood clots to the consistency of soft currant jelly. Venous stasis, distant parenchymal injury, and herniation of the cerebellar tonsils may result. If death is escaped, the swelling subsides in time and blood is absorbed, but the cavity remains. Even in the course of years, the glia makes little attempt at repair.

SIGMOID VOLVULUS can often be identified by a unique radiologic sign. If the ileocecal valve is incompetent, the two parts of the obstructed sigmoid coil are uniformly expanded to the same diameter, observes M. Arias Bellini, M.D., of Montevideo, Uruguay. With a competent valve the colon is also blocked and expanded, but the cecum and ascending colon are much wider than the descending portion. Roentgenograms in standing and supine positions sometimes suffice for diagnosis. A barium enema may indicate sigmoid volvulus if the barium remains in the rectosigmoid region or passes the obstruction and enters the distended coil, from which the medium cannot be expelled.

Radiology 53:268-270, 1949.

BRONCHIAL STONES are more common than heretofore suspected. Using laminagraphy, Eugene Freedman, M.D., and James H. Billings, M.D., found 7 instances in one year at Cedars of Lebanon Hospital, Los Angeles. The usual source is perforation of calcified tuberculous lymph nodes. Concretions should be sought when paroxysmal cough is associated with bronchial obstruction, pulmonary suppuration, or hemorrhage if radiography shows calcific shadows in consolidated areas.

Radiology 53:203-215, 1949.

Medical Forum

Discussion of articles published in MODERN MEDICINE *is always welcome. Address all communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Gastric Suction after Cesarean Delivery*

TO THE EDITORS: I believe that gastric suction of infants should be routine after cesarean section, as do Drs. Sydney S. Gellis, Priscilla White, and William Pfeffer. I have used it recently and have been surprised at the amount of fluid obtained.

CECIL W. SEIBERT, M.D.
Waterloo, Iowa

► TO THE EDITORS: I do not think gastric suction on babies born by cesarean section should be done routinely, as suggested by Drs. Sydney S. Gellis, Priscilla White, and William Pfeffer. This procedure is unnecessary in a great majority of cases, and is actually traumatic in many.

Obstetricians are impressed with the high incidence of respiratory difficulty, asphyxia, and strangulation in these babies as compared with those delivered by the vaginal route.

Several months ago, I heard Dr. Fred H. Falls of Chicago express the opinion that as the baby passes along the birth canal and over the perineum in vertex presentation, the chest is squeezed in such a manner as to force from the bronchial tree, and to some extent the other air passages, mucus and amniotic fluid that has collected. This does not occur in cesarean birth. Dr. Falls has attempted to overcome this by having an assistant hold the newborn baby by the feet while he gently compresses the chest toward the nasopharnyx, and strips the passages of any mucus. The nasopharnyx is then aspirated.

I believe if a baby is so treated, placed in a crib on one side with the head in a dependent position, and the upper air passages aspirated as frequently as fluid accumulates, the obstructive complications to the newborn delivered by cesarean section will be largely eliminated.

WILLIAM DURWOOD SUGGS, M.D.
Richmond, Va.

*MODERN MEDICINE, July 15, 1949, p. 64.

Ménière's Syndrome*

TO THE EDITORS: Regarding the rationale of vitamin B therapy for Ménière's syndrome, a fundamental medical issue is brought up which every individual physician meets daily. The issue is whether to treat the patient's symptoms or his disease.

Ménière's syndrome is not a diagnosis but a group of signs and symptoms, and treating symptoms without

*MODERN MEDICINE, Sept. 1, 1949, p. 74.

(Continued on page 98)

What do you demand in a toxoid, Doctor?

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Of course, doctor, you want the best possible combination of these advantages.

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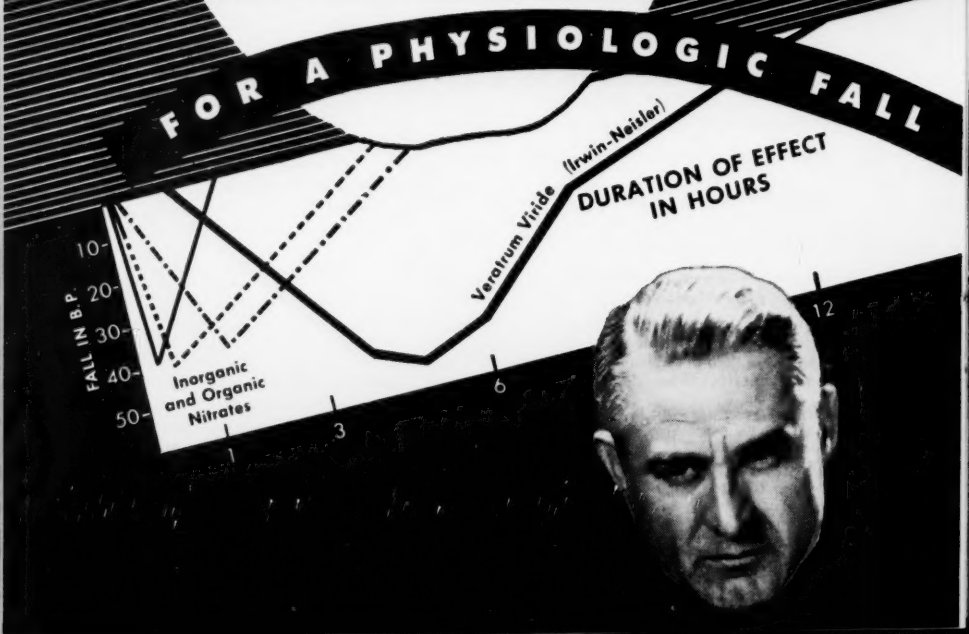

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IN BLOOD PRESSURE

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knowing the condition from which they arise is a sure way to court disaster. Unfortunately patients may pay with their lives because of this lazy way of practicing medicine.

It would be well for physicians to attend more clinical pathologic conferences and see unveiled the many conscientious mistakes of the best clinicians who have made earnest efforts to arrive at a diagnosis and even then failed to stem the tide which carried the patient to his death. It should not take any great stretch of the imagination to see how many times these instances of death will be multiplied if we start pumping large amounts of vitamin B into every patient who has Ménière's syndrome and allow the diagnosis or origin of his trouble to go wanting. We know that all excess intake of vitamin B must be excreted, usually unused.

One should never criticize unless he does it constructively and supports his own argument by deeds rather than words. Therefore I refer to my recent article, "The Association of Hyperglycemia, Elevated Blood Pressure, Increased Pulse and Latent Vertical Phoria" *(Eye, Ear, Nose & Throat Monthly* 28:359-370, 1949), which touches on Ménière's syndrome. Among the patients mentioned in this article are many who have had vitamin B therapy without relief, so at least we will need something other than vitamin B to take care of all who have Ménière's syndrome.

Ménière's syndrome represents a heterogeneous group of cases. The medical profession must ferret out separate causes for each type of case constituting the group. Vitamin B may have a proper place in the partial relief of many, or complete relief of a smaller number, but with the etiology varying from one type to the other, it is expecting too much of any single drug or vitamin to clear up all cases in the syndrome.

I am reminded of the hundreds of patients with pellagra I saw as a boy in Georgia who had vitamin B deficiency in its worst form but who did not have Ménière's. In practice I now see scores of vitamin-B deficiency cases to one of Ménière's syndrome.

I do not wish to detract from any man's effort to bring light where there is darkness, and I am sure this was Dr. Miles Atkinson's purpose in publishing his admirable work with vitamin B therapy. But I dare say that many of his cases will ultimately be found to have an abnormality in blood and body chemistry as the reason for the Ménière-like symptoms. Hyperglycemia is but one of the causative agents, and certainly is not cured by vitamin B therapy.

The work I have submitted does not solve Ménière's syndrome, but I dare say it gets nearer to the basic cause than treating mere symptoms.

E. H. COACHMAN, M.D.
Muskogee, Okla.

Correction of Hypospadias*

TO THE EDITORS: In connection with the article by Drs. Fred Z. Havens and Albert S. Black, in my opinion chordee should be corrected at or about the age of five. Reconstruction of the urethra should be done at or just after puberty.

PAYSON S. ADAMS, M.D.
Omaha

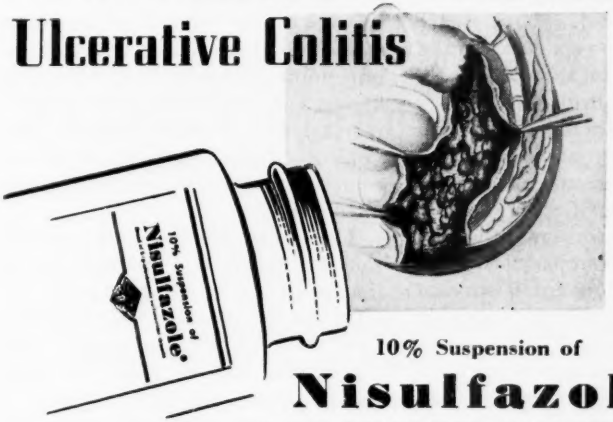
*MODERN MEDICINE, Sept. 15, 1949, p. 71.

● Now, there is an effective ally against the disease known for its rasping difficulties.

This is Nisulfazole — no recruit, but under trial for eight years — a sulfonamide which differs by carrying a substituted nitro radical. It is given as a suspension, intrarectally, where in relatively high concentration it is in contact with the pathological area.

Of 47 chronic ulcerative colitis patients in an early series treated with Nisulfazole Suspension, 37 could be followed for five years; 34 were then symptom free; three were markedly improved. Some received the drug for 26 months with frequent blood counts and urinalyses. No untoward effects were seen.[1]

An Advance in the Therapy of Ulcerative Colitis



Full facts about Nisulfazole sent to physicians on request.

1. Major, Ralph H., Am. J. Med. 1:485 (Nov.) 1946.

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Retropubic Prostatectomy*

TO THE EDITORS: The retropubic approach to the prostate gland is a distinct advance in prostatic surgery. Our first experience with this method was in 1945 after reading the technic as suggested by Dr. Terence Millin and hearing him at the meeting of the American Medical Association in Atlantic City and later at the meeting of the American Urological Association in Boston. Since that time, we have done well over 200 operations without a fatality.

The large or medium sized gland is preferred for this approach, the fibrotic type being reserved for the transurethral procedure. We follow the Millin technic altogether, having found it to be most agreeable. The number of days of catheter drainage and the stay in the hospital have been considerably reduced. The catheter is removed in four to six days and the patient dismissed in ten days or so, healed and able to urinate freely.

The greatest satisfaction has been derived in total retropubic prostatectomy for early carcinoma of the prostate gland, using the Czerny incision. This approach makes an otherwise difficult operation comparatively easy and is less likely to entail surgical error than the perineal approach. The perineal approach has one advantage, however. A section for biopsy can be more readily removed through the perineum, since the posterior lobe is the most common site of carcinoma.

After excising the urethra at the apex of the prostate gland outside the capsule a splendid exposure of the seminal vesicles, vas, and even the ureters can be obtained by elevating the prostate gland at the apex and exposing the posterior portion of the bladder. The seminal vesicles with sheath can be dissected and removed under adequate vision. We now include the sheath. We have not found it necessary to remove a great portion of the bladder or transplant the ureters into the colon, but these procedures can be easily accomplished by the retropubic approach.

The careful identification of the organism and the selection of the proper antibiotic before and after operation provide a smooth and prompt recovery.

GRAYSON CARROLL, M.D.

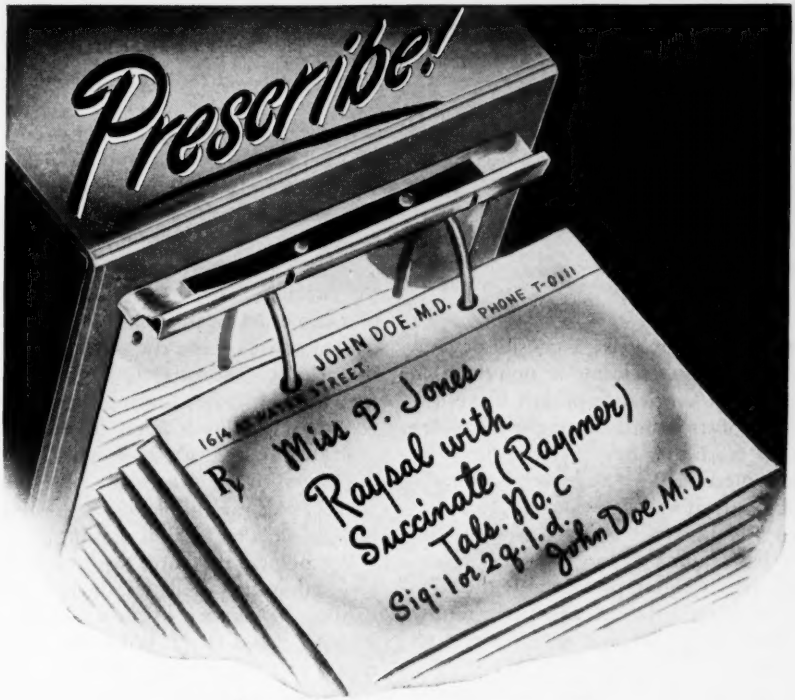
St. Louis

► TO THE EDITORS: It is difficult to imagine anyone who is proficient at transurethral resection resorting to retropubic exposure, with its well-known risk of osteitis pubis, for the removal of a sclerotic prostate containing calculi, when the transurethral approach is so much safer and so effective.

The retropubic approach for early cancer is inferior to the perineal in that, with the former approach, one must cut the prostate across and elevate it before the presumably cancerous area can be palpated. From the perineum one comes upon the suspected area in the posterior lobe first—a decided advantage.

Whether the very large benign hypertrophies, or the smaller ones in the presence of stiff hips, strictures, and so forth, should be enucleated supra- or retropubically appears to be

*MODERN MEDICINE, Aug. 15, 1949, p. 67.



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a matter of personal taste. There is much to be said for the retropubic approach in these situations, although we need to know more about the incidence of osteitis pubis in ordinary hands.

C. D. CREEVY, M.D.

Minneapolis

► TO THE EDITORS: I consider retropubic prostatectomy a definite advance in surgical approach to vesical neck obstructions. Both the mortality and morbidity have been reduced by this method. This approach is in keeping with normal physiologic function of the prostatic method since there is less trauma to the mucosa. Its continuity is better preserved and dissection from adjacent structures to the gland is cleaner and under direct vision.

Hemostasis at times is somewhat difficult, but this was also the "bugbear" of the older methods.

NORVELL BELT, M.D.

Frederick, Md.

Heparin Therapy of Coronary Thrombosis*

TO THE EDITORS: Concerning the recent article by Drs. Leo Loewe and H. B. Eiber, on our service we are now using anticoagulants routinely in cases of coronary thrombosis, since in our opinion a cooperative study carried on under the auspices of the American Heart Association proved conclusively that their use has resulted in definite lowering of mortality. Such a lowering has not been apparent in a series of 50 patients whom we treated within the past year, but we believe that our series is too small for the statistics to be valid.

We use both heparin and dicumarol, discontinuing the former as soon as the dicumarol has resulted in sufficient reduction of prothrombin activity. Incidentally, we have, during the past two years, been carrying on a controlled study on the use of dicumarol in patients with congestive heart failure, a series now running well over 300 cases. A significant reduction of mortality has occurred, which can be attributed to the practically complete absence of thromboembolic complications in the treated group.

We believe that in a hospital with good laboratory facilities, the only advantage of heparin over dicumarol is its more rapid effect. We believe that if the technics for determining prothrombin activity are carefully standardized, dicumarol can actually be given with greater safety than heparin. If, however, good laboratory facilities are not available, as in the case of general practice in small communities, heparin controlled by determinations of coagulation times is safer, though probably less effective.

EDGAR HULL, M.D.

New Orleans

► TO THE EDITORS: In my opinion, anticoagulant therapy is valuable in coronary thrombosis, and dicumarol has been used when no known contraindications existed. I am not able to discuss with authority the use of heparin in coronary thrombosis since I have used it only on occasions to initiate therapy during the period in

*MODERN MEDICINE, Aug. 1, 1949, p. 51.

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IN ACUTE AND CHRONIC SINUSITIS

Bacitracin-Nasal-C.S.C. is a valuable means of reducing the period of disability when acute sinusitis complicates coryza. Bacitracin, through its specific antibiotic properties, destroys many of the pathogens which flourish in the nose and accessory nasal sinuses. Desoxyephedrine, through its vasoconstrictor influence, improves ventilation and sinus drainage, thus enhancing the action of bacitracin. Bacitracin-Nasal-C.S.C. may be administered by means of a nebulizing spray or by the Parkinson lateral head-low position. Available in ½ ounce bottles on prescription at all pharmacies.

1. **Nonallergenic, even on** repeated administration.
2. **An aqueous solution** which does not inhibit ciliary activity.
3. **Nonirritant, isotonic.**
4. **May be administered to both adults and infants.**

CSC

When dispensed by the pharmacist each cc. of Bacitracin-Nasal-C.S.C. provides: bacitracin 250 units, desoxyephedrine hydrochloride 2.5 mg. (0.25%), sodium benzoate 1%. The solution is stable at room temperature for 5 to 7 days; at refrigerator temperature for 3 to 4 weeks.

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which the prothrombin level of dicumarol was being established.

It seems to me that depot heparin offers a chance for anticoagulant therapy to physicians whose work is done in community hospitals where reliable prothrombin level determinations are not available. The cost of prolonged treatment with heparin, however, is still relatively great.

EUGENE H. DRAKE, M.D.
Portland, Me.

Liver Function of Chronic Alcoholics*

TO THE EDITORS: I do not see how one can expect to distinguish liver damage caused by ingestion of alcohol from that due to poor diet or other adverse factors by using laboratory or any other means except the clinical history. After all, so far as we can determine pathologically when we have liver tissue under the microscope, the damage seen in alcoholics is very comparable in all of its stages with that seen in liver damage from a variety of other etiologic causes. Therefore, it is unlikely that any laboratory tests of liver function would show any distinction in alcoholics. In my own experience this has been borne out.

The reports of Drs. Walter L. Voegtlin and William R. Broz comprise a very interesting study on this subject. They were apparently dealing with the early phases of liver damage. In other studies the use of the aspiration needle biopsy has contributed immensely to our knowledge of the pathology in these cases.

DOLPH L. CURB, M.D.
Houston

*MODERN MEDICINE, Sept. 1, 1949, p. 50.

► TO THE EDITORS: When one starts reviewing opinions of others on a controversial subject, confusion results. So it is in this case. Even as far back as the early 1930's, when it was almost axiomatic that a cirrhotic liver was due to alcoholism, doubters of this theory began appearing.

It is my opinion that a great majority of investigators now believe that liver damage is not due to alcohol per se but to dietary insufficiency. Fatty infiltration of the liver is the precursor of cirrhosis, and this may be caused by dietary insufficiency, deficiency diseases, chronic ulcerative colitis, diabetes mellitus, or pigment as seen in hemachromatosis. Withdrawal of dextrose from body metabolism may result in fatty liver.

Production of cirrhosis with alcohol experimentally has not been successful. However, as one authority states, if cirrhosis is suspected, inquiry usually is made concerning the use of alcohol; if alcoholism is suspected, a diligent search for cirrhosis will be made. Aside from this, little, if any attention is given the matter. Case history studies are most unreliable, except when the two conditions are under investigation.

It would be unfortunate, however, for the layman to gain the impression that alcohol is blameless in the development of cirrhosis; certainly it must be much to blame and given substance. All in all, the decision is not closed, but I feel that the consensus now is that liver damage from ingestion of alcohol cannot be distinguished from that due to poor diet and other adverse factors.

MORRILL L. ILSLEY, M.D.
Claremont, Calif.

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Phenobarbital (¼ gr.)	16.2 mg.

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Phenacetin (3 gr.)	**194 mg.**
Acetylsalicylic Acid (2½ gr.)	**162 mg.**
Hyoscyamine Sulfate	**0.03 mg.**
Phenobarbital (¼ gr.)	**16.2 mg.**

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► TO THE EDITORS: Ethyl alcohol has never been firmly established as the direct etiology of the so-called "alcoholic cirrhosis," but there is no question that by inference it has been implicated as a contributory factor. Approximately 50% of all patients with Laennec's cirrhosis are heavy drinkers, but by the same token, in countries with a large population of Mohammedans, who are abstainers, the incidence of cirrhosis is equal to that of the United States.

The present concept points to alcoholism as a cause of poor dietary habits and alterations in metabolism of essential food elements and vitamins, this nutritional deficiency in turn being the direct cause of the liver pathology.

There is little argument that in the late stages of cirrhosis, namely the small hobnail liver, nothing in the pathologic picture will indicate whether the patient was or was not alcoholic. However, there is some evidence that in the earliest stages of liver involvement specific cytologic changes are present which may be attributable to ethyl alcohol.

Mallory, in 1933, reported the presence of an acidophilic hyaline reticulum in the hepatic cells of the central portion of the lobule, characteristic of the earliest phase of alcoholic cirrhosis. This initial lesion precedes the development of portal fibrosis. However, he was later able to produce the identical lesion by experimental phosphorus poisoning.

Hall and Morgan have pointed out that there is a very specific subacute alcoholic cirrhosis which may be differentiated pathologically from other forms of liver disease. Its differential points include a more cellular type of portal connective tissue proliferation, a more widespread necrosis of hepatic cells, and again, as observed by Mallory, a hyaline necrosis of the cytoplasm.

It must be remembered that the cases of Hall and Morgan were in the subacute stage of the disease and that this picture is comparable to that of early toxic cirrhosis due to other causes than alcohol. From a clinical standpoint these observations are purely of academic interest, since pathologic observations in the very early stages of the disease are not usually within the realm of the physician, and laboratory investigation cannot distinguish the exact type of cellular lesion.

At the present time, for all practical purposes, there is no method by which liver disease associated with chronic alcoholism can be distinguished from hepatitis and cirrhosis due to other causes.

SIDNEY A. PORTIS, M.D.

Chicago

Giant Cell Tumor of Bone*

TO THE EDITORS: Dr. T. M. Prossor's article refers particularly to osteoclastoma. It is accepted that this tumor is best treated by radiotherapy. Only bone tumors that are known to be radiosensitive can be so treated. Unfortunately, most bone tumors are not radiosensitive and require surgery.

ABRAHAM MYERS, M.D.

Philadelphia

*MODERN MEDICINE, Oct. 1, 1949, p. 81.

► TO THE EDITORS: The relative merits of radiologic and surgical treatment for bone tumors cover a rather wide and unsettled field, but certain principles can be enunciated from the conjoint experience of the many who have made comprehensive studies in it. There are certain instances in which radiologic treatment holds sway, and certain ones in which surgery is the treatment of choice.

When any bone tumor is quite accessible, there can be no question—complete excision is the method of choice. This applies to both benign and malignant tumors.

In osteogenic sarcoma, the exact surgical procedure depends upon the degree of malignancy. If it is grade 1, more conservative surgery is indicated—in grade 4, amputation is the method of choice. This is evidenced by the number of five-year cures in published series of cases.

In fibrosarcoma, early amputation offers the best prognosis.

Giant cell tumor of bone is best treated by surgery; the exact type of operation depends upon the location of the lesion. Complete excision when possible is always the method of choice. Inaccessible lesions are treated by radiologic method only as second choice. In malignant giant cell sarcoma, amputation gives the best prognosis.

Of the vascular tumors of bone, accessible benign hemangiomas are treated surgically if treatment is required. If not accessible, radiologic treatment is indicated. Since benign hemangiomas rarely give much trouble, too great risk is not being taken. On the other hand, in Ewing's tumor or malignant angioma or endothelioma the treatment of choice is radiologic.

Multiple myeloma is not affected by any form of treatment, surgical or radiologic.

M. E. PUSITZ, M.D.

Topeka, Kan.

Acute Rheumatic Disease in Children*

TO THE EDITORS: Since we know that at least 50% of adult patients with definite rheumatic endocarditis give no recognizable history to suggest rheumatic infection, the comments of Dr. Leo M. Taran are timely. He points out that acute rheumatic heart disease is not a clear-cut entity, but it seems most unwise to cast aside laboratory evidence.

While acute carditis may occur without elevation of the sedimentation rate, white blood cell count, temperature, pulse rate, or antistreptolysin, such occurrence is so rare that perhaps it is unwise to stress the point.

In average practice one sees so much unwarranted cardiac invalidism that it is felt that the practitioner must avail himself of as much concrete evidence as possible with definite associated cardiac findings. Only then will the incidence of functional murmurs treated as organic be reduced. Occasional organic murmurs are going to be missed for a few years, but this is certainly a lesser evil than the tragedy of a child saddled for life with the diagnosis of heart disease because of a functional murmur.

G. I. BELL, M.D.

Edmonton, Alb.

*MODERN MEDICINE, Feb. 15, 1949, p. 55.

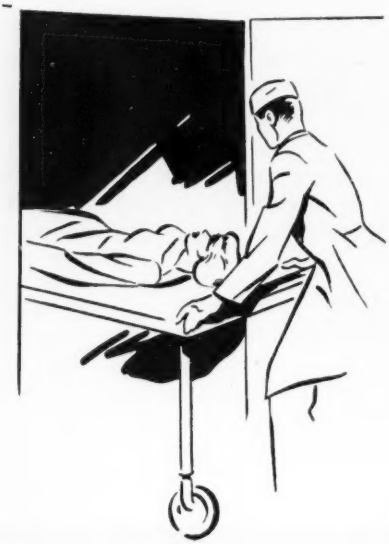
Diagnostix

Here are diagnostic challenges presented as they confront the consultant from the first clue to the pathologic report. Diagnosis from the Clue requires unusual acumen and luck; from Part II, perspicacity; from Part III, discernment.

Case MM-155

THE CLUE

ATTENDING M.D: The young woman in the next room is twenty-nine years of age and has had abdominal complaints for a long time and many operations. In the past nine years she has had uterine suspension, salpingectomy, drainage of a right polycystic ovary, cholecystectomy, two dilations and curettages, and amputation of the uterine cervix. Now the surgeons want to do a laparotomy.



VISITING M.D: The operations have apparently been of little value. This is about the time that one begins to suspect a psychiatric or at least an obscure medical condition. Let us assume that it's the latter to start with. What clues can you give me?

ATTENDING M.D: For twelve years she has had a palpable mass in the left lower quadrant. It is tender and quite large—perhaps 15 by 10 cm. During an exploratory operation eight years ago, the left ovary was found to contain numerous cysts, and it was drained and marsupialized. We have no details of this operation. For six years the patient has had recurring attacks of bilateral costovertebral pain radiating to the epigastrium and, during these spells, abdominal tenderness and rigidity.

VISITING M.D: I presume nothing was found at these operations to account for her symptoms; at least, she apparently still has attacks of pain.

ATTENDING M.D: Correct.

PART II

ATTENDING M.D: She has been hospitalized now because of the abdominal mass, tenderness, rigidity, nausea, vomiting, and an intermittent, cramp-like pain, which is intensified just before a bowel movement.

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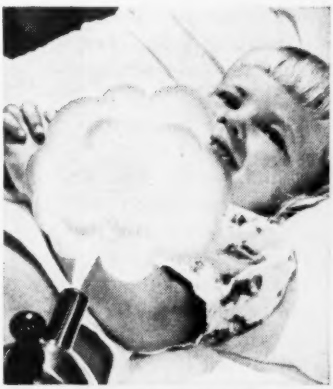
VapoRub's well-balanced formula contains 7 volatilizing ingredients including menthol, thymol, camphor, and oil of eucalyptus.

Used in steam, VapoRub provides soothing vapors that are comforting to a patient—particularly when dryness and irritation of the mucous membranes are prominent features accompanying the respiratory infection.



IN VAPORIZER

IN BOWL

VapoRub can be used in a vaporizer or a bowl of boiling water. It can be used as often as needed—for all the family.

Vicks VapoRub is available in practically every home. In recommending it, you can be sure that it's already on hand for instant use. When steam inhalation is prescribed, recommend . . . Vicks VapoRub.

She also has diarrhea with twenty to thirty soft stools a day.

VISITING M.D: *(Walking into the room. The patient has a Wangensteen tube in the bowel and is getting a blood transfusion)* Now, what immediately preceded the symptoms you have described?

ATTENDING M.D: For six months the patient has had scanty, irregular menses; for three weeks the abdominal mass has been growing more sensitive and enlarging. For two weeks she has had unbearable abdominal pain. Today there is some rebound tenderness, greater on the left.

VISITING M.D: Do the laboratory tests help us?

ATTENDING M.D: She has had the works: from blood urea and amylase to urine porphyrin. Results of all the special tests are negative and those of the routine studies can be accounted for on the basis of dehydration or mild infection. The sedimentation rate is 70. She has lost only 10 lb. in the past five years.

VISITING M.D: How about films of chest and abdomen?

PART III

ATTENDING M.D: The chest film is negative. The roentgenogram of the abdomen reveals numerous cystic calcified areas measuring about 0.2 to 1.3 cm. They are round, smooth, discrete, are more dense peripherally, and some appear lobulated. All other x-ray studies, including excretory urograms, are negative.

VISITING M.D: Mmmm . . . Young woman, recurrent episodes, ovarian cysts, abdominal calcification. *(To himself)* Paraffinoma, echinococcus cysts, calcified mesenteric nodes, phleboliths, biliary or urinary calculi, calcified fibroids, enteroliths, calcified primary or metastatic tumor . . . pseudomyxoma peritonaei . . . partial bowel obstruction. *(Aloud)* I'd like to examine the patient proctoscopically. *(After examination)* I note some small rectal nodules and a stricture-like shelf on the anterior rectal wall. I believe this is pseudomyxoma peritonaei. I'd advise peritoneoscopy before surgery, but would continue conservative therapy for bowel obstruction until things are quieter. Of course, it may be necessary to explore, but I'd hesitate to do that now.

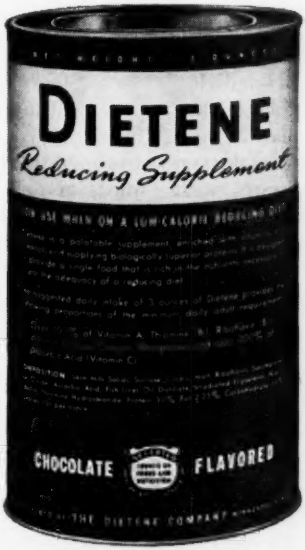
PART IV

ATTENDING M.D: *(One week later)* The patient responded well and peritoneoscopy and biopsy confirmed your opinion.

VISITING M.D: Undoubtedly she will continue to have episodes of partial bowel obstruction. These nodules and tumor-like growths usually result from rupture of a mucocele of the appendix or pseudomucinous cystadenoma of the ovary. The pseudomucinous material and the cells producing it are spread through the abdominal cavity. The peritoneum reacts with chronic inflammatory changes, and adhesions are formed. There may be proliferation of the implanted cells with small, tumor-like growths. Some believe the mucoid material produces the lesions, but I doubt it, although the material is undoubtedly an irritant and provokes a foreign-body reaction.

It is a Question of Management..

The treatment of obesity is simple. It is the management of the obese patient that presents the problem.



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Interpreting Medicine for the Layman

STEVEN M. SPENCER*
Associate Editor, The Saturday Evening Post

THE private practice of medicine is much more medicine and much less private than it was ten or fifteen years ago. The doctor, striving to familiarize himself with and to evaluate the parade of new drugs and technics, finds an eager public looking over his shoulder—and sometimes breathing down the back of his neck.

Gone are the days when a practitioner could keep the details of diagnosis to himself and dismiss Mrs. Brown with a reassuring word to the effect that "it's nothing serious—and if it is come back on Friday and we'll try something else." Mrs. Brown will want to know the name of the germ that bit her. She will also ask if the prescription contains a sulfa, which upset her digestion last time she took it, or penicillin, which upset her budget.

However much you may be annoyed by the sound of a little medical knowledge rattling around in a patient's skull, you probably will agree that the public has a legitimate interest in your problems and progress. Steven M. Spencer believes that this interest can be a healthy situation not only for the patient but for the doctor and his profession as well. People who fully understand and appreciate what the great American medical profession has done and is continuing to do are less likely to accept a compulsory health insurance scheme or any other socialized medicine package wrapped in Washington and tied with yards of red tape.

Much of the public's information about medicine is obtained through the press. If that information is sound the public reactions on medical matters are more apt to be sound than otherwise.

Medicine is not something people take instinctively, as they take food or water. It is a commodity on which they must first be sold. Selling is largely a matter of telling. That is where physicians and writers and editors can work together. For it seems logical that the more people know about what doctors can do to help them, the more readily will they come to doctors for help, and the more readily will they rally to the doctor's point of view in controversies over medical economics.

Although most people take medicine only when they or their physicians feel it is needed, information about medicine can be ingested, without discomfort, at almost any time. For the human machine has ever been a fascinating subject.

A popular interest in medicine has always existed, even though the doctors and editors may have underestimated it in the past. One of the first

* A science writer looks at medicine. J. Omaha Mid-West Clin. Soc. 10:33-41, 1949.

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BIBLIOGRAPHY: 1. Couperus, M.: J. Invest. Dermat. *13*:35, 1949. 2. Tronstein, A. J.: Ohio State M. J., *in press*. 3. Goldman, L.: Connecticut M. J. *13*:624, 1949. 4. Patterson, R. L.: Work in progress. 5. Domenjos, R.: Schweiz. med. Wchnschr. *76*:1210, 1946. 6. Burckhardt, W., and Rymarowicz, R.: Schweiz. med. Wchnschr. *76*:1213, 1946.

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The world wide Geigy organization—established in Switzerland in 1764—has a noteworthy history in the production of synthetic organic compounds which have found wide acceptance as chemicals of highest quality. Leadership in organic research and synthesis have led naturally to the development of original pharmaceuticals now widely prescribed in virtually every country of the world.

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newspapers printed in Europe carried in 1494 an account of the outbreak of syphilis in Naples following the return of Columbus and his men from the New World. Every new development that comes over the medical horizon is greeted with a fresh spurt of printer's ink. The sulfa drugs were one of the big stories of the century. Penicillin, the discovery and application of which were filled with drama, made an even greater impact on the people's imagination.

Most medical news is good news. It has been said that the good and the peaceful make dull reading. But in this day when so much of the news is bad, good news is doubly welcome. And medicine is not dull at any time. Even when an article does not announce a brand new treatment but simply presents a summary of the most up-to-date knowledge on the cause and treatment of any disease, or reports a promising development along the research front, it gets a good reading. For the reassurance which comes from a fuller understanding of a condition affecting the reader or a member of his family is itself ample justification for publishing the information.

A case in point was the article, "I Have a Scar on My Heart," a personal experience story by a Detroit advertising man, W. A. P. John, which the *Saturday Evening Post* printed last winter. It did not announce a sensational new therapy. It was just a well-written account of how the

writer had come through a coronary attack, how he had taken a philosophic view of the situation, how he had slowed down his pace, how, in brief, he was following his doctor's orders and getting along fine.

The response to this article was overwhelming. Mr. John received nearly 500 letters within a month after publication, virtually all of them commendatory and many expressing gratitude for some individual help or encouragment the reader had derived. Several wives thanked Mr. John for having dramatized the dangers of overdoing, and said their husbands had at last begun to heed the warning, even though up to that time they had completely disregarded the same advice from their own doctors.

This is one kind of medical information that is helpful to the patient. If it makes the doctor's job any easier it may be considered helpful to him, too.

Education of the public in the value of early diagnosis of cancer has now reached the point where the demand for examinations exceeds the facilities for conducting them. Dr. Elise L'Esperance, Director of the Strang Cancer Prevention Clinic in New York, has stated that there is a waiting list of 6,000 in that area alone, and that a comparable situation exisits in Philadelphia, Pittsburgh, Chicago, and other cities where cancer detection centers are operated.

Now a layman who is interested in

On the Dual Value of *Candy*

Socially candy has long been accepted as a pleasant part of our daily lives. From early childhood on, candy is considered an appropriate accompaniment of the festive spirit of birthdays, holidays, anniversaries, and other joyous occasions.

In recent years, with the advancing knowledge of nutrition, the values of candy as a worth-while part of the daily diet have also become recognized. Most of the kinds of candy manufactured today are made of a number of valuable foods which contribute to the extent they are used to the satisfaction of many nutritional needs.*

Whether enjoyed as a delectable tidbit during a friendly gathering—or served at the end of a family meal—or eaten as a quick energy food following strenuous activity, candy has a unique and valid place in the human dietary.

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*The candies in the manufacture of which milk, butter, eggs, fruits, nuts or peanuts are used, *to this extent* also (a) provide biologically adequate proteins and fats rich in the unsaturated fatty acids; (b) present appreciable amounts of the important minerals calcium, phosphorus, and iron; (c) contribute the niacin, and the small amounts of thiamine and riboflavin, contained in these ingredients.

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medical details often expects more information from his doctor than the latter may feel he has time to supply. Here again the press can perhaps be of help to both the physicians and the patients.

For many readers magazine articles answer questions which have long bothered them about the general nature of their ailments. Specific details about a patient's own case obviously can be supplied only by his doctor. But through the medium of the press, a type of background information can be provided that in the long run will save you an endless amount of time and your patients an endless amount of worry.

It is more and more to the advantage of the medical profession today to meet the public halfway on these matters, for it is the public to which the doctors must look for an increasing share of support for medical education and research. As taxpayers providing government grants and as voluntary contributors to a growing list of special campaigns, the people want to be kept informed on medical affairs and they want to be assured that the doctors examine both sides of medical economics questions. If the American medical profession is to have an electorate favorably disposed toward the physicians' views on compulsory health insurance, for example, that electorate must be kept sold on the American medical profession.

The story of American medicine

*ALSO KNOWN AS DETTOL

A proved antiseptic for obstetrical and surgical use

● Dett, known as Dettol throughout the British Empire and other parts of the world, is now available to the medical profession of the United States.

Dett, although deadly to germs, is gentle to human tissue. This clean, clear liquid with an agreeable odor is safe, effective, non-irritating and non-staining. Physicians who have used Dettol in other countries will welcome its introduction in the United States under the name of Dett.

For a generous size sample, and literature, write to: The R. T. French Co., Pharmaceutical Dept., Rochester 9, New York.

DETT *THE MODERN WEAPON AGAINST INFECTION*

is living, contemporary history. As such it must concern itself with living men and women. Medical contributions are not made by disembodied spirits. They are made by individuals and teams of individuals—research workers in their laboratories, surgeons in their operating rooms, general practitioners and specialists in their offices and at the bedside. And the light of the whole group will shine but dimly, so far as the public eye is concerned, if the light of each member of the group is hidden under his own private bushel of anonymity. The history of medicine would be dull reading indeed if it contained no mention of the names and personalities of men like Harvey, Jenner, Beaumont, Pasteur, Osler, Cannon, Cushing, Fleming.

The argument for using names is simply that the public has a right to know whose work is being described and whose opinions are reflected in the text of the article. To adopt a policy of not quoting authorities would open the way for unreliable reports on medicine by irresponsible publications—and there are a few. In addition, we feel the story of medicine's advance is the story of people as well as of facts.

The tradition of medical modesty apparently is based on the theory that if it were declared ethical to blow one's own horn, the quacks would blow loudest, attract most of the business, and ruin the public's health. The theory is all right, but the fact of the matter is that the quacks disregard all rules against hornblowing and do pretty well for themselves. Self-advertising, however, should be clearly differentiated from bona fide medical news. Accurate articles on medical progress are useful and writers should be able to obtain information from doctors without fear of subjecting the latter to censure by their colleagues.

A Code of Cooperation already has been adopted by the Colorado State Medical Society and the press and radio of that state.

The code sets up a system of official spokesmen for each county society—usually the president, secretary, and publicity chairman. These men and women, as well as spokesmen for the hospitals, are to make themselves available to the press and may be quoted "in matters of public interest for purposes of authenticating infor-

one and one-half acres

MERCUHYDRIN®

The fluid that inundates the tissues during congestive heart failure may pass through approximately one and one-half acres of capillary wall. Following an intramuscular or intravenous injection of MERCUHYDRIN, edema fluid comprised of water and salts, chiefly sodium chloride, is mobilized back through the one and one-half acres of the capillary bed and is eliminated through the kidneys. The diuresis obtained with MERCUHYDRIN benefits not only the patient with palpable edema, but also the patient subject to cardiac decompensation. "The effect on dyspnea in these cases of left-sided failure is probably largely a result of diminution in pulmonary edema, even though the latter is clinically occult."*

The management of cardiac decompensation is greatly facilitated and the comfort and well being of the patient is greatly increased by administration of

MERCUHYDRIN *early*, concurrently with digitalization

MERCUHYDRIN in a systematic schedule of *repeated* doses as maintenance therapy

MERCUHYDRIN by *intramuscular* injection, well tolerated locally and systemically, and affording highly effective diuresis

MERCUHYDRIN (meralluride sodium) is available in 1 cc. and 2 cc. ampuls

*Fishberg, A. M.: Heart Failure, Lea and Febiger, Phila., 1946, p. 733.

Lakeside Laboratories, INC. MILWAUKEE 1, WISCONSIN

mation." The code states specifically that this action by the spokesmen "shall not be considered by their colleagues as a breach of the time-honored practice of physicians to avoid personal publicity, since it is done in the best interests of the public and the profession." That single sentence cuts to the very core of the problem.

Colorado's program is a tremendously encouraging sign that the physicians and the press are alive to the importance of giving accurate medical information to the public. If the code works out, plans of this type, perhaps broadened in some respects, may be adopted in other states.

For the story of medicine is one which the press and the public are eager to hear. Your town wants to know what kind of medicine it has, what facilities and services are available, what types of operation its surgeons are performing, what research projects are under way. The public wants to know what you are doing and saying. Your story and every doctor's story is part of the fabric of its life. It is the story of big and little miracles, of birth and growth and struggle and triumph. It is the story of man himself, and that is still the biggest and best story on earth.

b FOR BALANCED

Tyree's Antiseptic Powder offers the busy physician a *balanced* vaginal douche . . .

BALANCED Psychologically . . . by imparting immediately a sense of cool, clean, gratifying comfort, Tyree's restores the woman patient's subjective balance and makes her amenable to further curative treatment.

BALANCED Physiologically . . . by correcting hypo-acidity present in the vaginal pathology with Tyree's, it is possible to approximate the normal vaginal pH of 4.0—a condition very hostile to the growth of vaginal infections.

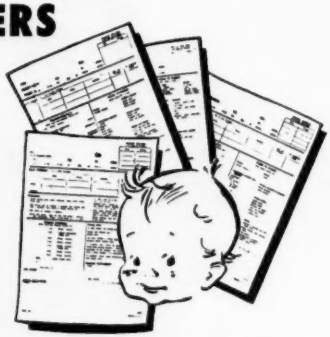
BALANCED Therapeutically . . . finally, Tyree's value as a vaginal douche is positive, because it balances *effectiveness* with *safety*, avoids complications caused by caustic, irritating douching, while it acts as an effective treatment in vaginal infection. Try Tyree's the next time you prescribe a vaginal douche. Write for literature and professional samples.

Tyree's ANTISEPTIC POWDER

J. S. TYREE, CHEMIST, INC., 15th and H Streets, N. E., Washington 2, D. C.

Manufacturers of **CYSTODYNE,** Tyree,
for the treatment of genito-urinary infections

HANDY TIMESAVERS FOR YOU!



PEDIATRIC FEEDING DIRECTIONS

(birth to 3 mos., 3-6 mos., 6-10 mos., over 10 mos.)

Easy to use, complete, adaptable to individual patients. Help mothers follow your directions accurately. Each contains: formula or diet charts; food lists; food preparation methods; weight record; spaces for your directions, next appointment. Available in pads of 50 each, imprinted if desired.

ALSO... This *Gift* For Your Young Patients

Eight-page book with pictures for the youngster to color. Written in primer style. Emphasizes health practices and other good habits you and the mother want the child to develop. Yours—to give your young patients.

Use this coupon for sample copies and a postage-paid order card. After examination, mail card to order in quantity.

NO COST OR OBLIGATION!

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Please send the FREE material checked below:

☐ C848 1 set Feeding Direction Forms
☐ C958 1 child's Color Book

*Name*_____ *M. D.*

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When Rapid Growth Calls For HIGH IRON and THIAMINE— Remember RALSTON

Instant Ralston — enriched whole wheat cereal—is a *rich* source of iron and thiamine. A single 1-ounce serving supplies the following percentages of the minimum daily requirement:

	1-6 years	6-12 years	adults
IRON	113%	84.9%	84.9%
THIAMINE	84%	56%	42%

Plus 3.5 Gm. PROTEIN

Cooks in 10 seconds

Instant Ralston supplies riboflavin and niacin, too... in taste-appealing, readily digested form.

Short Reports

INDUSTRIAL MEDICINE

Mercury Poisoning from Fingerprint Photography

A new form of a long-established occupational hazard, chronic mercurialism, is reported by Drs. John N. Agate and Monamy Buckell of London. Policemen who develop latent fingerprints are the victims. In preparation for photographing prints left at the scene of a crime, a powder is dusted over the area. The most commonly used powder by British and American police forces is mercury with chalk. Exposures in excess of two hundred and fifty hours a year are considered to constitute a definite risk. Examination of 32 policemen of the Lancashire constabulary regularly engaged in developing latent prints revealed 7 who had chronic mercury poisoning. The three main symptoms are stomatitis, tremor, and excessive irritability.

Lancet 257:451-454, 1949.

NEUROPSYCHIATRY

Alpha Rhythm of the Brain

Voluntary muscular movements are apparently influenced by the electrical rhythms of the brain. Dr. G. O. Kibbler and associates of Whitchurch Hospital, Cardiff, Wales, made simultaneous recordings of the alpha rhythm and eye opening in response to an auditory signal and measured the time interval between the two. The eye tended to open at the peak of the rhythm.

Nature 164:371, 1949.

TREATMENT

Relief of Radiation Sickness

Dramamine is effective, prophylactically and therapeutically, against radiation sickness. A total of 300 mg. is given in three equal dosages: thirty to sixty minutes before radiation, an hour to an hour and a half after, and three hours after. Dr. John W. Beeler and associates of the Mayo Clinic, Rochester, Minn., report that the relief of symptoms was significantly greater from Dramamine than from placebos. Drowsiness is the most noticeable side effect. A combination of Dramamine and pyridoxine may be desirable for the treatment of severe cases.

Proc. Staff Meet., Mayo Clin. 24:477-483, 1949.

HORMONES

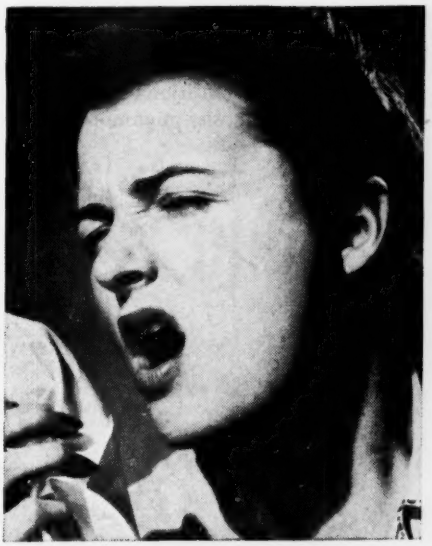
Effect of Cortisone on Cerebral Activity

In addition to relieving pain, stiffness, and disability of patients with rheumatoid arthritis, cortisone apparently acts as a mental stimulant. Drs. Edward W. Boland and Nathan E. Headley of the University of Southern California, Los Angeles, made electroencephalographic studies before and after administration of the hormone in 2 cases. In both instances tracings made at the termination of cortisone acetate administration revealed increases in frequency of the alpha waves. In one case the increase was 8.8 and in the other 9.2%.

J.A.M.A. 141:301-308, 1949.

*"The Favorite Medication"**

Among Antihistaminics Used in the Pioneering Study AGAINST THE COMMON COLD



"Neo-Antergan was found to have little or no sedative effect in the majority of cases in which it was given, and thus became the favorite medication of the ambulatory patients who had had experience with any of the other antihistaminic drugs.***"**

—Brewster, J. M., Antihistaminic drugs in the therapy of the common cold, U. S. Naval Medical Bulletin 49:1-11, Jan.—Feb. 1949.

Neo-Antergan†—*the favorite antihistaminic*—is characterized by high antihistaminic potency and a high index of safety. It may be administered with confidence whenever safe, effective antihistaminic action is desired.

†Neo-Antergan is the registered trade-mark of Merck & Co., Inc. for its brand of pyranisamine.

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RAHWAY, N. J.

Neo-Antergan®

MALEATE

(Brand of Pyranisamine Maleate)

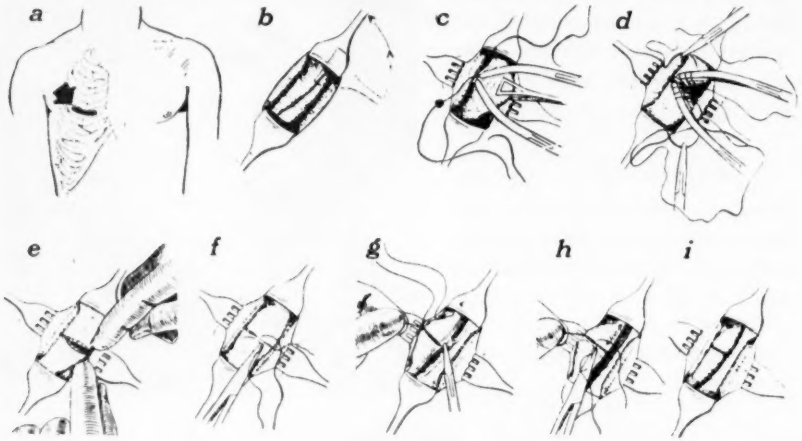
(N-*p*-methoxybenzyl-N′, N′-dimethyl-N-*α*-pyridylethylenediamine maleate)

COUNCIL ACCEPTED

DIAGNOSIS

Diffuse Pulmonary Lesions Differentiated by Biopsy

When conventional methods fail to establish the nature of diffuse pulmonary lesions, biopsy may permit a rapid, accurate diagnosis. Lung biopsy has been used in 50 cases by Dr. Karl P. Klassen and associates of Ohio State University, Columbus, to diagnose such conditions as tuberculosis, histoplasmosis, pneumoconiosis, sarcoidosis, and cancer. The procedure is well tolerated and does not induce pneumothorax or hemothorax. Dissemination does not occur in instances of bacterial or fungous diseases. With patient supine, an 8-cm. incision, *a*, is made over the fourth anterior intercostal space, 4 cm. from the edge of the sternum. Blades of a medium-sized Richardson retractor inserted parallel with the ribs and rotated 90 degrees outward, *b*, spread intercostal space to expose the interlobar fissure. Slight increase of intrabronchial pressure by the anesthetist causes the lung to herniate through the incision. The edge of the lobe is grasped by a small lung clamp and a mattress suture of 000 chromic surgical gut with a swaged curved needle at each end is placed at the apex of the biopsy site, 2 cm. from the lung margin. With two hemostats approximating the suture, the isolated wedge of pulmonary tissue is excised, *c*. The two ends of the suture are then run down, as an over-and-over stitch, to the periphery of the lung on each side, *d*, the clamps are removed, and suture is tightened and tied, *e*. One end of the suture is then used as a continuous Cushing stitch to appose visceral pleural surfaces above, *f*, and, after transfixion at the site of the mattress suture, brought back to the edge of lobe on the inferior surface, *g*, *h*, tied and cut, *i*. A 14 F catheter is placed into the pleural space and the wound closed. After instillation of 100,000 units of penicillin in 5 cc. of saline, catheter is withdrawn.



Arch. Surg. 59:694-704, 1949.

"The best inhaler they have ever used!"

the new S.K.F. BENZEDREX INHALER

So much better that we have discontinued 'Benzedrine' Inhaler

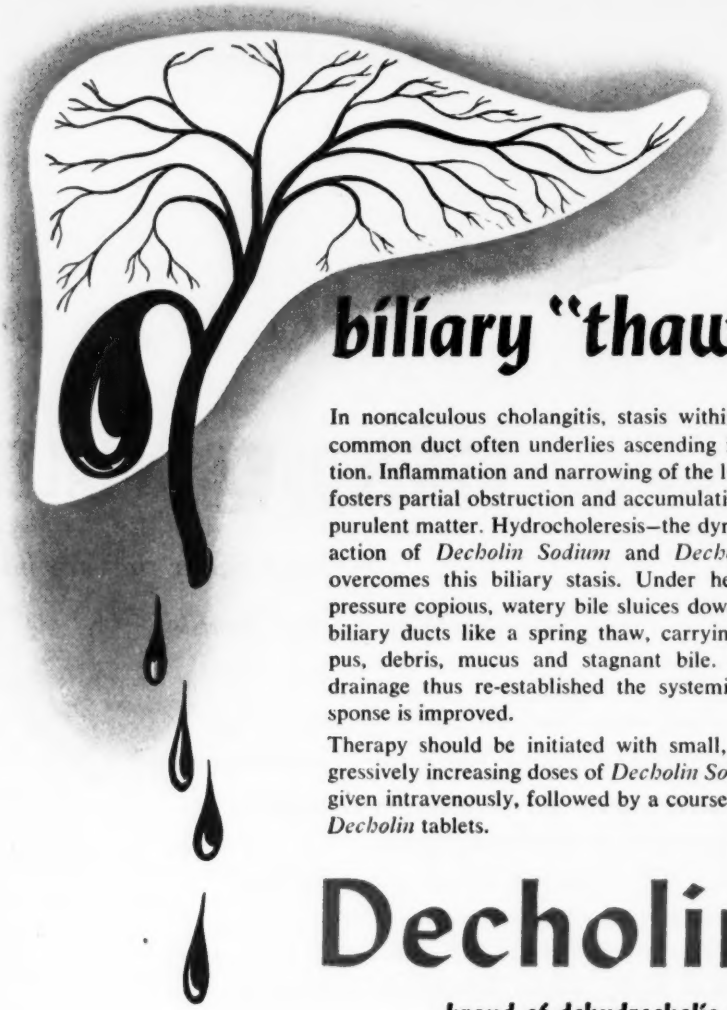
Physicians tell us that they and their patients find BENZEDREX INHALER the best inhaler they have ever used.

The active ingredient of BENZEDREX INHALER is 1-cyclohexyl-2-methylaminopropane, a new S.K.F. compound. It has exactly the same agreeable odor as Benzedrine*, gives even more effective and prolonged shrinkage, and does NOT produce excitation or wakefulness.

We are sure you will find that BENZEDREX INHALER is the best volatile vasoconstrictor you have ever used.

Smith, Kline & French Laboratories, Philadelphia

*'Benzedrine' (racemic amphetamine, S.K.F.) and 'Benzedrex' T.M. Reg. U.S. Pat. Off.



biliary "thaw"

In noncalculous cholangitis, stasis within the common duct often underlies ascending infection. Inflammation and narrowing of the lumen fosters partial obstruction and accumulation of purulent matter. Hydrocholeresis—the dynamic action of *Decholin Sodium* and *Decholin*—overcomes this biliary stasis. Under hepatic pressure copious, watery bile sluices down the biliary ducts like a spring thaw, carrying off pus, debris, mucus and stagnant bile. With drainage thus re-established the systemic response is improved.

Therapy should be initiated with small, progressively increasing doses of *Decholin Sodium* given intravenously, followed by a course with *Decholin* tablets.

Decholin®

brand of dehydrocholic acid

Tablets of 3½ gr. in bottles of 25, 100, 500, and 1000.

Decholin Sodium® (brand of sodium dehydrocholate) in 20% aqueous solution, ampuls of 3 cc., 5 cc., and 10 cc., boxes of 3 and 20.

DECHOLIN and DECHOLIN SODIUM, trademarks reg. U. S. and Canada.

AMES

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VITAL STATISTICS

Maternal Mortality Rates at Record Low

The United States had no more than 1.2 maternal deaths per thousand live births in 1948, a drop of 0.1 from 1947, according to preliminary estimates from state public health agencies. More important than the overall decline in mortality is the fact that the highest state rate in 1948 was 2.7, less than two-thirds of that for the best state in 1933. This figure refutes the charge that rapid improvement in health in this country is limited to the wealthy sections.

J.A.M.A. 141:333-334, 1949.

STATISTICS

Health of Sailors Improves

The disease rate of the U.S. Navy was lower in 1948 than at any time since records were started in 1850. A major factor in the health record, according to Rear Admiral C. A. Swanson, Navy Surgeon General, was the drop in venereal cases from 85.8 per 1,000 in 1947 to 66.6 in 1948.

PUBLIC HEALTH

9,000 Free Wigs

The British Ministry of Health reports that 4,500 Britons have ordered wigs under the national health plan. Each Briton who obtains a doctor's certificate that he needs a wig is entitled to two.

TREATMENT

Xanthine Dust for Asthma

Micropowdered aminophylline or theophylline inhaled in small amounts relieves asthmatic attacks more rapidly than large intravenous doses. From 5 to 60 mg. in a lactose vehicle is taken as needed with a specially designed inhalator. Dr. George V. Taplin and associates of the University of California, Los Angeles, obtained good results in 30 of 35 chronic cases. Slight asthma was checked for one to eight hours and severe spasm alleviated for twenty to forty minutes.

Ann. Allergy 7:513-523, 1949.

PEDIATRICS

Moth Balls Cause Anemia

Severe hemolytic reaction may be caused by a reputedly harmless household article, naphthalene moth balls. Drs. Wolf W. Zuelzer and Leonard Apt of Wayne University, Detroit, report 4 cases in which two-year-old children acquired fulminating hemolytic anemia and hemoglobinuria from sucking moth balls. Symptoms appearing in one to four days included listlessness, loss of appetite, diarrhea, vomiting, and pallor. All patients recovered after blood transfusions, sodium bicarbonate, and sodium lactate.

J.A.M.A. 141:185-190, 1949.

On this Important Subject

of Breakfast... and Sustained Mental Acuity

The complexities and fast pace of modern living make it all the more essential that mental acuity be sustained throughout the day, including such times as the pre-noon hour when under many conditions mental acuity may wane. Driving high-powered motor cars in congested traffic, working at intricate machines in industry, the pressing demands of business activities, even the demands of household duties, present potential hazards demanding—for safety's sake—that mental acuity be constantly at highest pitch. In children too, alertness must be at maximum intensity at all times to prevent accidents during hours of play.

A Good Breakfast — Improved Mental Acuity

In a recent study* conducted jointly by the departments of physiology and nutrition of a prominent medical college, a direct relationship between late-morning mental acuity and breakfast habits was definitely established. The experiments were planned to learn whether eating breakfast, and eating no breakfast or taking coffee only, made a difference in the subjects' mental acuity during the pre-noon hour.

Six young women graduate students were used as subjects and mental acuity was determined by measurement of simple and choice reaction times to light stimuli.

These experiments definitely showed:

(1) That the *omission* of breakfast increases reaction time, hence acts detrimentally;

(2) That when breakfast is eaten, reaction time is reduced—hence favorably influenced.

In other words, eating breakfast better prepares one for the demands of living and, from a practical standpoint, serves as a safety precaution against potential accidents due to breakfast skimping or skipping.

Breakfast and Sound Nutrition Planning

For the foundation of an adequate breakfast, nutrition and health authorities recommend a basic breakfast pattern of fruit or juice, cereal, milk, bread and butter. The cereal serving—breakfast cereal and milk—has many outstanding nutritional advantages. It contributes biologically complete protein; the B vitamins, thiamine, riboflavin and niacin; the minerals, calcium, phosphorus and iron; and needed food energy. It is bland and easily digested and offers many varieties of form, consistency and taste. Its marked economy is a distinctive feature.

* Reprint of the study will be sent on request.

The presence of this seal indicates that all nutritional statements herein have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

CEREAL INSTITUTE, INC.

135 South La Salle Street • Chicago 3

A RESEARCH AND EDUCATIONAL ENDEAVOR DEVOTED TO THE BETTERMENT OF NATIONAL NUTRITION

EXPERIMENTAL MEDICINE

Treatment of Aneurysms

Periaortic injection of 0.5% dicetyl phosphate in olive oil produces a gradual fibrosis and obliteration of large fusiform aneurysms in animals and might be adapted to the treatment of thoracic and abdominal aneurysms of syphilitic and arteriosclerotic origin. Dr. J. K. Berman and associates of the Indianapolis General Hospital believe that a 0.9% solution is probably the best concentration for treatment of human beings. The mixture is heated and injected beneath the pleura and peritoneum around the thoracic and abdominal aortas. A curved number 18 needle with a blunt bevel is used. The size of the aneurysm determines the curvature of the needle used. A tube is employed to hold the needle steady and avert leaks into pleural or peritoneal cavities. Extravasation of the solution is prevented by manual pressure of firm packing at the site of injection. A small piece of gelfoam is placed over the puncture wound. The dicetyl phosphate solution may also be used to produce vascular constriction for investigation of coronary disease, portal hypertension, renal ischemia, and constricting pericarditis.

J. Indiana M.A. 42:889-893, 1949.

ORTHOPEDICS

Strength of Bones

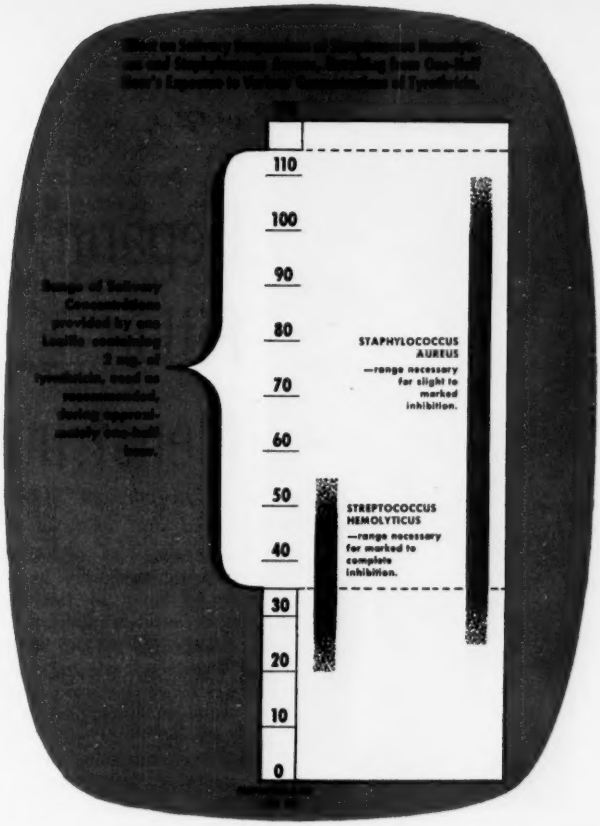
Human bone is twice as strong as seasoned hickory; one-fourth as strong as cast iron. Unit cubes from the long bones of arms and legs will stand a strain of 23,000 lb. in a compression test before crushing, according to the National Bureau of Standards. Human bone is comparatively weak against twisting strains and lets go at about 3,000 lb. a square inch.

ANTIBIOTICS

Polymyxin B for Meningitis

When other measures fail to cure influenzal meningitis, employment of polymyxin B may be lifesaving. Dr. B. M. Kagan of Michael Reese Hospital, Chicago, reports recovery of an infant, thirteen months old, who had had influenzal meningitis four weeks with no sign of improvement despite treatment with streptomycin and sulfadiazine and, finally, with specific rabbit antiinfluenzal serum. These medications were then stopped and polymyxin B was given intramuscularly every four hours in the amount of 50,000 units per kilogram per twenty-four hours. During the first day 1 mg. of polymyxin B was given intrathecally and on the next two days 3.5 mg. was instilled daily. On the fourth day of the new therapy the baby seemed to be more toxic than before, but improvement thereafter was rapid without symptoms or signs or toxicity. Polymyxin B was discontinued after six days. Examination of the child three months after recovery revealed no neurologic or other physical defects.

Pediatrics 4:319-322, 1949.



Effective Salivary Levels of Tyrothricin

Used as recommended, one Lozille maintains for approximately *one-half hour* salivary tyrothricin levels as shown in chart.

The sustained salivary concentrations insure broad antibacterial action against gram-positive organisms responsible for acute oropharyngeal infections.

Tyrothricin, unlike topical penicillin, is remarkable for its *lack of local toxicity*. Pleasant-tasting, Lozilles also provide propesin, for non-toxic, long-lasting analgesia.

Each Lozille contains *2 mg.* of tyrothricin and 2 mg. of propesin.

Supplied in vials of 15 Lozilles.

LOZILLES

(Loh-Zeels) TYROTHRICIN-PROPESIN LOZENGES

WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N. J.

Free flow with

Heparin/ Pitkin Menstruum

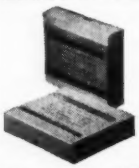
'WARNER'

an anticoagulant preparation with prolonged action for the prevention and treatment of thromboembolic disorders.

HEPARIN/PITKIN MENSTRUUM 'Warner' is a safe and clinically established means of providing prolonged anticoagulation action in the body.

One subcutaneous injection of HEPARIN/PITKIN MENSTRUUM 'Warner' is usually sufficient to increase the blood coagulation time for a period of 24 to 48 hours . . . without the necessity for the cumbersome, discomforting and time-consuming procedures usually required when maintaining blood fluidity in thromboembolic disease.

Heparin / Pitkin Menstruum
'WARNER'



is available in 200-mg and 300-mg ampuls for subcutaneous injection, cartons of 6 ampuls each, with or without vasoconstrictors.

WILLIAM R. WARNER & CO., INC.
NEW YORK ST. LOUIS LOS ANGELES

GRANTS

To Keep Young Doctors on Faculty Posts

In an attempt to offset the lure of private practice and uphold teaching standards, the Markle Foundation has granted $940,000 to medical colleges. Bulk of the funds, states John M. Russell, New York City, will be used to assist 28 young doctors in faculty positions. Institutions benefited include: Bowman Gray School of Medicine, Duke University, New York University, Medical College of Virginia, University of Illinois, Washington University, Yale University, University of Pennsylvania, University of California, and the Medical Film Institute.

GRANTS

Rheumatic Fever Research

Seven New York medical colleges and research groups have received grants totaling $200,000 from the Masonic Foundation for Medical Research and Human Welfare. The funds are to be used to forward study on the cause and cure of rheumatic fever.

BIOCHEMISTRY

Short Cut to Cortisone

The necessity for using osmium textroxide, a rare and expensive chemical, in the synthesis of cortisone may be eliminated. Scientists of the research staff of Glidden Company, Cleveland, have announced development of a method of creating cortisone from the soybean which may ultimately make the drug relatively plentiful and less expensive than at present.

RESEARCH

Institute for Pediatrics

The Playtex Park Research Institute has recently been formed to encourage study of child development and diseases of children. Funds of the organization will be used entirely to augment research in existing institutions. The institute program is supported by the International Latex Corporation, Dover, Del. The governing board, which will administer the finances and supervise all projects, is composed of the following physicians:

Dr. Katherine Bain, U.S. Children's Bureau, Washington, D.C.; Dr. Sidney Farber and Dr. Charles A. Janeway, Children's Medical Center, Boston; Dr. John P. Hubbard and Dr. Joseph Stokes, Jr., Children's Hospital, Philadelphia; Dr. Eva Landsberg, New York City Department of Health; Dr. Milton I. Levine and Dr. Samuel Z. Levine, New York Hospital, New York City; Dr. Charles F. McKhann, Jr., University Hospital of Cleveland; Dr. Henry G. Poncher, University of Illinois, Chicago; Dr. Bret Ratner, Flower and Fifth Avenue Hospital, New York City; Dr. Milton J. E. Senn, Yale University, New Haven, Conn.; Dr. Ashley A. Weech, University of Cincinnati; Dr. Myron E. Wegman, Louisiana University, New Orleans; Dr. James L. Wilson, University of Michigan, Ann Arbor.

PUBLIC HEALTH

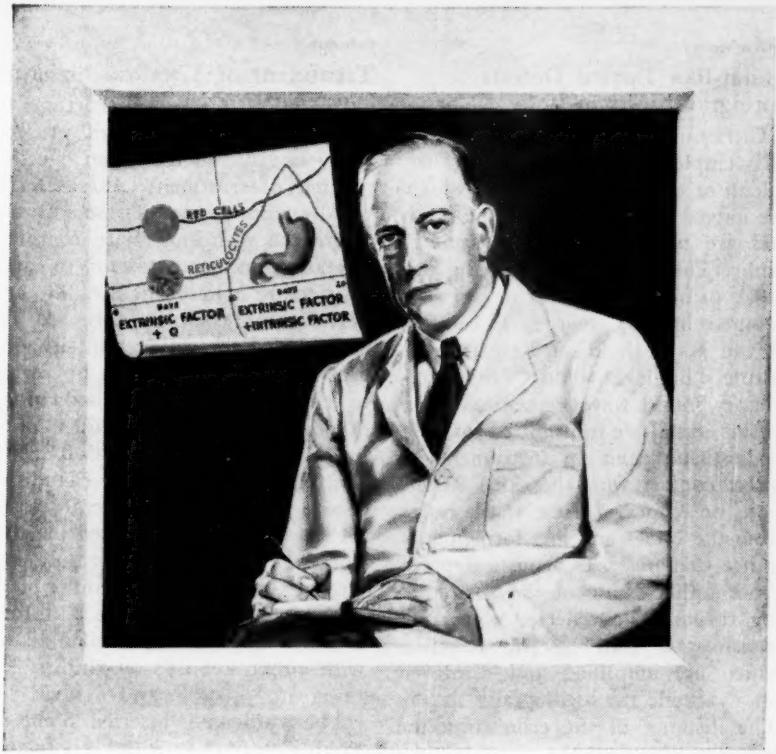
WHO to Fight Plague

India has been proposed as the first demonstration ground for plague eradication by an international team of health experts from the World Health Organization.

The pioneer investigations in the study of hematology by the eminent Doctor William B. Castle, have contributed immeasurably in the further study and development of medicinals for the treatment of all types of anemias. Doctor Castle's early observation of an existing extrinsic and intrinsic factor assisted greatly in clarifying the normal processes of hemopoiesis. The Armour Laboratories, as a pioneer in the field of endocrinology, is keenly appreciative of Doctor Castle's contributions in the study of hematopathy

Twelfth in the series, PORTRAITS OF PIONEERS in Endocrinology. A full-color reproduction of this painting suitable for framing, is available upon request. On your professional letterhead, please address:

ARMOUR *Laboratories*
CHICAGO 9, ILLINOIS



Dr. William B. Castle, 1897-

Dr. Castle was graduated by the Harvard Medical School in 1921. Four years later he began a career in clinical investigation in the field of blood diseases at the Thorndike Memorial Laboratory of the Boston City Hospital. He is director there and Professor of Medicine in Harvard.

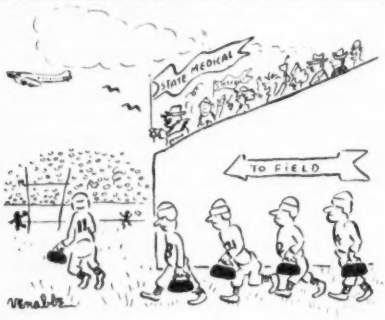
Following the great discovery by Minot and Murphy of the beneficial effect of liver feeding, Dr. Castle and his several associates began a series of carefully controlled observations which have demonstrated that the nutritional deficiency in pernicious anemia is "conditioned" by the lack of gastric secretion characteristic of this disease. Their experiments have shown that normal erythropoiesis in man requires both a food (extrinsic) and a gastric (intrinsic) factor and that deficiencies of these factors, together with defective intestinal absorption, are the reasons for other macrocytic anemias such as those of sprue and pregnancy. Dr. Castle and his associates have shown that the food (extrinsic) factor is related to Vitamin B_{12}.

In Puerto Rico, in 1931, Dr. Castle and his associates were able for the first time to control the macrocytic anemia and diarrhea of tropical sprue by injections of liver extract. Also demonstrated was the striking effectiveness of iron in the treatment of the hypochromic anemia of hookworm disease with or without the removal of the parasites. During the past few years Dr. Castle, in collaboration with others, has conducted experimental studies of the mechanisms of red cell destruction in various types of hemolytic anemias.

NEW DEVICES

Radar-like Device Detects Foreign Objects in Body

Ultrasonic energy may be successfully employed to detect and localize calculi or other foreign bodies which are lodged in soft tissues of the body and are not visible by roentgenography. The technic for applying the radar principle to medicine was developed by Dr. George D. Ludwig at the Naval Medical Research Institute, Bethesda, Md. High frequency sound waves generated by a quartz crystal are transmitted into the body tissue from an instrument in direct contact with the skin. Reflections or echoes of these waves occur from the bones and any foreign substance that possesses acoustical properties unlike those of the surrounding tissues. The reflected waves are transformed into electric impulses which are amplified and displayed on a cathode ray oscillograph screen. The distance of the echo from the initial pulse gives the depth of the foreign body in the tissues. Although not yet tried on human beings, the method has been highly successful with animals, and the ultrasonic energy has not been harmful to the tissues.



UROLOGY

Treatment of Urethral Stricture

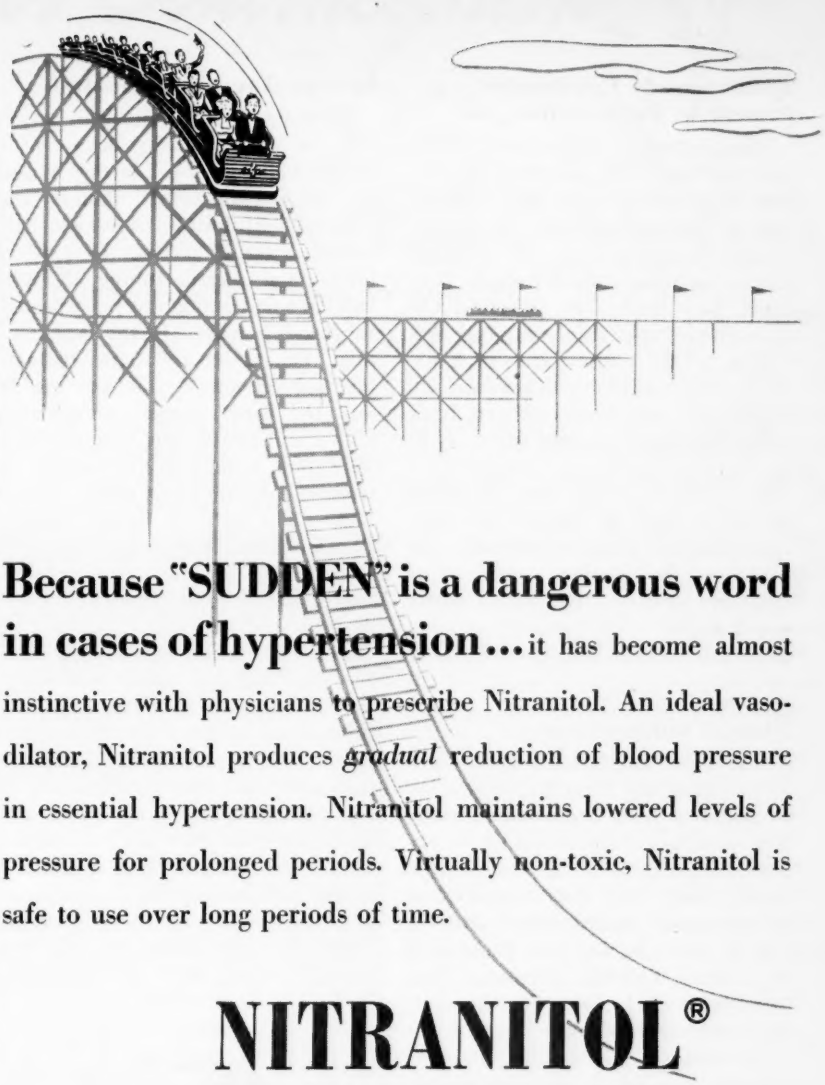
Dilatation of urethral strictures by insertion and retention of progressively larger catheters is an effective method of treatment. Anesthesia is usually unnecessary. Trauma is not as great as with immediate, complete dilatation and the tendency to rapid contracture is lessened. Bleeding and periurethral complications are decreased and the catheter in situ provides opportunity to clear up pyuria by daily irrigations. The disadvantage of prolonged hospitalization is offset by more enduring results. Recently Drs. R. Grant Reid and Claude A. Moore of Montreal General Hospital have gradually dilatated urethras of 7 patients with early results surpassing those obtained by other methods. After local anesthesia, a filiform is passed. The stricture is then dilated with either LeFort's or Phillips' followers to 14-16 F. and a small soft rubber catheter is inserted. Some patients may require anesthesia for this step. At two- to four-day intervals the catheter is replaced with progressively larger sizes. Penicillin and low doses of a sulfonamide are given routinely. In no instance have hemorrhage, hyperpyrexia, or chills been observed.

Canad. M.A.J. 61:278-280, 1949.

EVENTS

Marshall Heads Red Cross

Gen. George C. Marshall is president of the American National Red Cross, succeeding Basil O'Connor. Although Mr. O'Connor's term would not have expired until 1951, he resigned effective October 1 because of pressure of personal affairs.



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When sedation is desired. *Nitranitol with Phenobarbital.* (¼ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

For extra protection against hazards of capillary fragility. *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

DIAGNOSIS

Spontaneously Precipitable Protein in Polyarteritis

When protein precipitate appears spontaneously and persists in the serum of a patient who has a bizarre clinical picture, polyarteritis nodosa should be suspected. Dr. Harold Lepow and associates of Lincoln Hospital, New York City, observed the spontaneous appearance of a precipitate at 4° C. in the serum of a patient with proved polyarteritis nodosa. The precipitate differed from previously reported cold fractions in not redissolving at room temperature. The precipitate may also be found in other cases in which the albumin/globulin ratio is reversed, the cephalin flocculation reaction is strongly positive, and serum nitrogen is high.

Am. J. Med. 7:310-316, 1949.

PATHOLOGY

Platelet Adhesiveness

Use of a braided Fiberglas wick as an adsorbing filter for separation of adhesive from nonadhesive platelets simplifies enumeration of the relative proportions in the total platelet count, and may aid detection of predisposition to thrombosis. Drs. Sylvan E. Moolten and Leo Vroman of St. Peter's General Hospital, New Brunswick, N. J., find that the short exposure of blood on a large surface area tends to reduce the factor of platelet lysis which may cause error in the final calculations. A uniform wait between withdrawal and filtration of the blood is desirable since a longer or shorter interval leads to discrepancies in results.

Am. J. Clin. Path. 19:701-709, 1949.

NEW DEVICES

Balloon Tampon Hemostasis

Bleeding from esophageal varices may be controlled by means of a double balloon tube. The device used by Drs. Thomas B. Patton and Charles G. Johnston of Wayne University, Detroit, consists of 4 ft. of four-lumen plastic tubing. A Rehfuss tip small enough to pass through the nares is affixed to the largest lumen. Separately inflatable balloons are tied on; one 8 in. from the tip and the other, larger, immediately above and contiguous with the first. The third lumen may be used to introduce thrombin just above the balloons. The tube is passed through the nose into the stomach. The position is confirmed by aspiration, the lower balloon inflated to a diameter of 3 in. and pulled snug against the cardia. The tube is then taped to the nose and the upper balloon inflated with 200 to 250 cc. of air. The apparatus is left in place twelve hours with constant suction from the stomach; then the balloons are deflated. If bleeding has stopped, material aspirated from the stomach will be free of blood. The tube is left in place and the patient is given sips of fluid. Nourishment is gradually increased until a full diet is being ingested by the third day. Supportive treatment is necessary.

Arch. Surg. 59:502-506, 1949.

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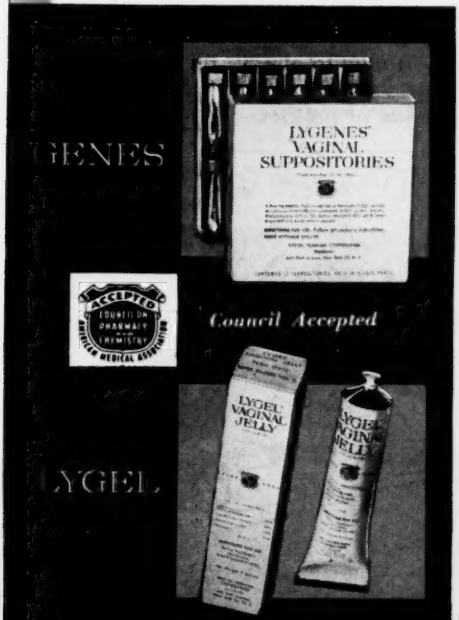

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Zinc Sulfocarbolate 0.50%
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LYGEL VAGINAL JELLY—A jelly of high spermicidal efficacy with freedom from irritation and ready patient-acceptance. Readily dispersible. Does not lose viscosity at body temperature. 3-oz. tubes.

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Washington Letter

(Continued from page 41)

the last days of Congress, the point has not been resolved.

The American Medical Association and some other organizations are strongly opposed to the principle of free treatment without a means test.

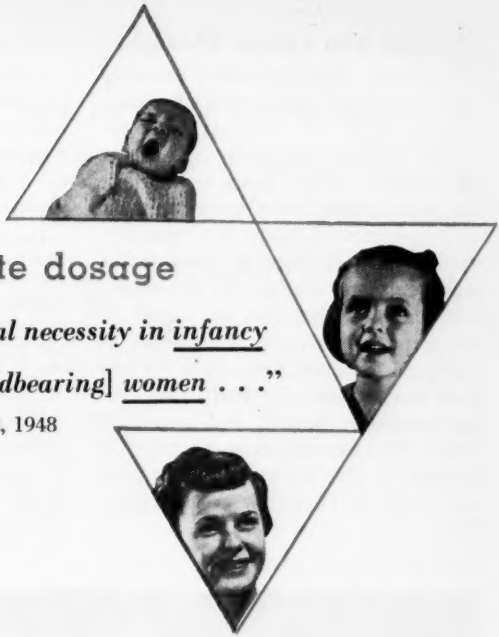
However, sentiment in Congress is overwhelmingly in favor of a school health bill. This bill passed the Senate without debate. It was tied up in a House committee, mostly because of the "means" issue. If it is not the law of the land now, it is certain to be shortly after the first of the year when the second session meets.

Under this "no means-test" clause, every private physician would be assured payment for treatment of school-age children. For a few years, some states might be expected to require an ability-to-pay test, but political pressure would bring all states into the "free treatment" class in a few years. It would, automatically, bring many millions of patients under a form of federal health insurance.

5 The direction this program takes will be largely determined by the private physician and professional associations. The law defines a specific role for the private physician in treatment of patients and for medical associations in administration.

The school health plan is the closest approach yet to a federal health program. It offers the physician an opportunity to observe the workings of the plan and to take a hand in formulation of policies.

"I'm sick of normal deliveries. This time I want a cesarean."



Iron in adequate dosage

"*is almost a physiological necessity in infancy and childhood and [childbearing] women . . .*"

Sundaram, S.K.: Lancet. 1:568, 1948

and Feosol *is iron in its* most effective form

Feosol—both the Tablets and the highly palatable Elixir—contains adequate dosage of ferrous sulfate, grain for grain the most effective form of iron. Feosol is easily absorbed and readily tolerated. Feosol effects rapid hemoglobin regeneration and prompt reticulocyte response.

Smith, Kline & French Laboratories, Philadelphia

Feosol Tablets
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the standard forms of iron therapy

Million Volt Cancer Therapy

Veterans Administration shortly will have ready the results of a continuing study of veterans who received million-volt x-ray treatment for cancer. Three years ago about 150 men received the treatments on an experimental basis. VA rounded up as many of them as possible for post-treatment studies, to determine the long-time benefits or harms of this type of therapy. The study is expected to throw some light on just how much x-ray the body can take for maximum benefit and minimum harm. The investigation is under direction of Dr. Aubrey O. Hampton of Garfield Hospital, Washington, D.C.

Appeal to Druggists

Federal Security Administrator Oscar Ewing, addressing the National Association of Retail Druggists, made a direct dollars-and-cents argument to win support for national health insurance. He said in part:

Certainly, every gain in our public health and other services is a gain for the drug trade. For the drug business flourishes most in those areas where the concern for health is the greatest. And the partnership of the druggists with the local public health doctor is as real as with the private physician.

For the last month of Congress, almost nothing was heard of the President's health plan. However, supporting studies are being revised in preparation for the next session.

Welfare Plan Redrafted

President Truman, turned down once on his plan for a cabinet department of education, health, and welfare, is trying again. The plan is being redrafted at the White House for presentation to Congress after the first of the year.

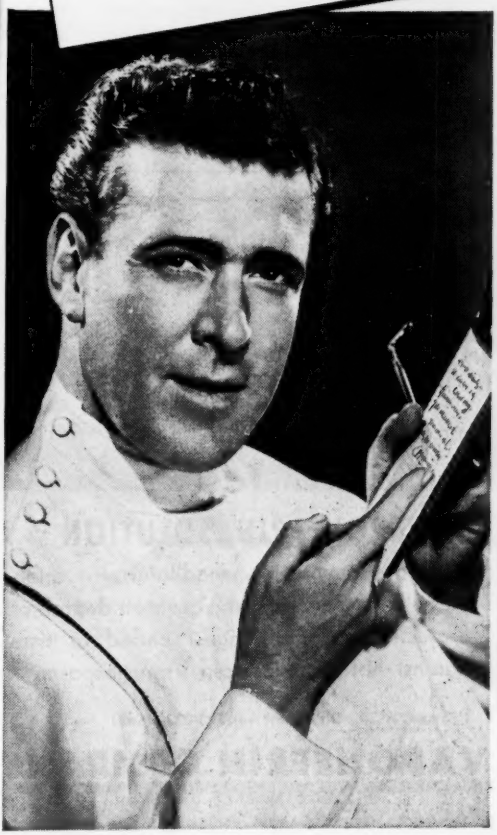
It is understood that some arrangement is being made to placate the private welfare organizations which felt that their activities would suffer under the proposed plan. However, the administration will not back down on including health activities in the new department. Last session this brought it into head-on conflict with American Medical Association and other professional organizations.

Atomic Research Accelerated

Russia's possession of the atomic bomb is having one valuable reaction: It has insured that basic atomic research will not be slighted for years to come. Funds for atomic research were trimmed slightly by the last Congress. However, a week after announcement that Russia had the bomb, a move was underway to get more money for basic research, including medical research. Sen. Brian McMahon, chairman of the joint atomic congressional committee, joined scientists in this appeal: We have made use of all the basic knowledge we had three years ago. In some fundamental phases of the subject our ignorance is abysmal.

THROAT SPECIALISTS REPORT ON 30-DAY TEST OF CAMEL SMOKERS—

"Not one single case of throat irritation due to smoking CAMELS!"



YES, these were the findings in a total of 2,470 weekly examinations of hundreds of men and women from coast-to-coast who smoked only Camels for 30 consecutive days! And the smokers in this test averaged one to two packages of Camels a day!

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MORE DOCTORS SMOKE CAMELS

than any other cigarette!

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THE DIAGNOSIS OF PANCREATIC DISEASE *by* Louis Baumann. 74 pp., ill. J. B. Lippincott Co., Philadelphia. $5

CLINICAL METHODS *by* Sir Robert Hutchison *and* Donald Hunter. 12th ed. 488 pp., ill. Cassell & Co., London. 17*s.* 6*d.*

HANDBOOK OF DIGESTIVE DISEASES *by* John Leonard Kantor *and* Anthony M. Kasich. 2d ed. 658 pp., ill. C. V. Mosby Co., St. Louis. $11

THE VALUE OF HORMONES IN GENERAL PRACTICE *by* William N. Kemp. 115 pp. Burgess Publishing Co., Minneapolis. $3

STOMACH DISEASE AS DIAGNOSED BY GASTROSCOPY *by* Eddy D. Palmer. 200 pp., ill. Lea & Febiger, Philadelphia. $8.50

BEDSIDE DIAGNOSIS *by* Charles MacKay Seward. 376 pp., ill. E. & S. Livingstone, Edinburgh. 17*s.* 6*d.*

Surgery

ADVANCES IN SURGERY, VOLUME 1 *edited by* William DeWitt Andrus *et al.* 566 pp., ill. Interscience Publishers, New York City. $11

BLOOD TRANSFUSION *edited by* Geoffrey L. Keynes. 574 pp., ill. Williams & Wilkins Co., Baltimore. $12.50

DAS AKUTE ABDOMAN: KLINIK UND THERAPIE DER AKUTEN LEBENSBEDROHENDEN BAUCHERKRANKUNGEN *by* Hubert Kunz. 357 pp., ill. Urban & Schwarzenberg, Vienna. 105 Sch.

TEXT BOOK OF SURGERY *by* Patrick Kiely. 1,184 pp., ill. H. K. Lewis, London. 45*s*.

Allergy

PROGRESS IN ALLERGY, VOLUME II *edited by* Paul Kallós. 356 pp., ill. Interscience Publishers, New York City. $7.50

PRÉCIS DES MALADIES ALLERGIQUES *by* Pasteur Vallery-Radot. 223 pp., ill. Editions Médicales Flammarion, Paris. 550 fr.

Anatomy

SOME NOTES ON GALEN'S ANATOMY *by* Wynfrid Laurence Henry Duckworth. 42 pp. W. Heffer & Sons, Cambridge. 2*s*. 6*d*.

ANATOMY OF THE FEMALE PELVIS *by* Frederick Arthur Maguire. 4th ed. 176 pp., ill. Angus & Robertson, Sydney. 42*s*.

VERTEBRATE BODY *by* Alfred Sherwood Romer. 643 pp., ill. W. B. Saunders Co., Philadelphia. $5.50

Anesthesia

GAS AND AIR ANALGESIA *by* R. J. Minnitt. 4th ed. 86 pp., ill. Baillière, Tindal & Cox, London. 5*s*.

Gynecology & Obstetrics

HAVING YOUR BABY: MODERN INSTRUCTIONS FOR EXPECTANT MOTHERS *by* Leonard H. Biskind. 96 pp. Western Journal of Surgery Publishing Co., Portland, Oregon. $2.50

THE MIDWIFE'S TEXT-BOOK *by* R. W. Johnstone. 4th ed. 400 pp., ill. A. & C. Black, London. 20*s*.

BIRTH CONTROL TODAY *by* Marie C. Stopes. 9th ed. 242 pp., ill. Alexander Moring, London. 6*s*.

Proctology

TREATMENT IN PROCTOLOGY *by* Robert Turell. 248 pp., ill. Williams & Wilkins Co., Baltimore. $7

Pharmacology

LECTURE NOTES ON PHARMACOLOGY *by* Joshua Harold Burn. 128 pp. Charles C Thomas, Springfield, Ill. $1.60

(Continued on page 158)

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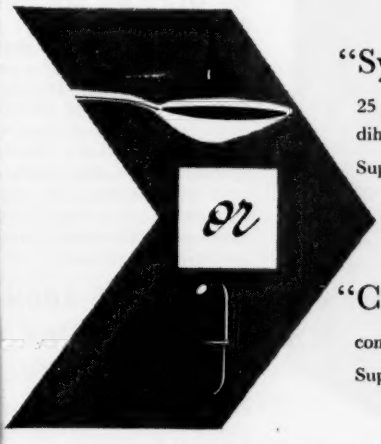

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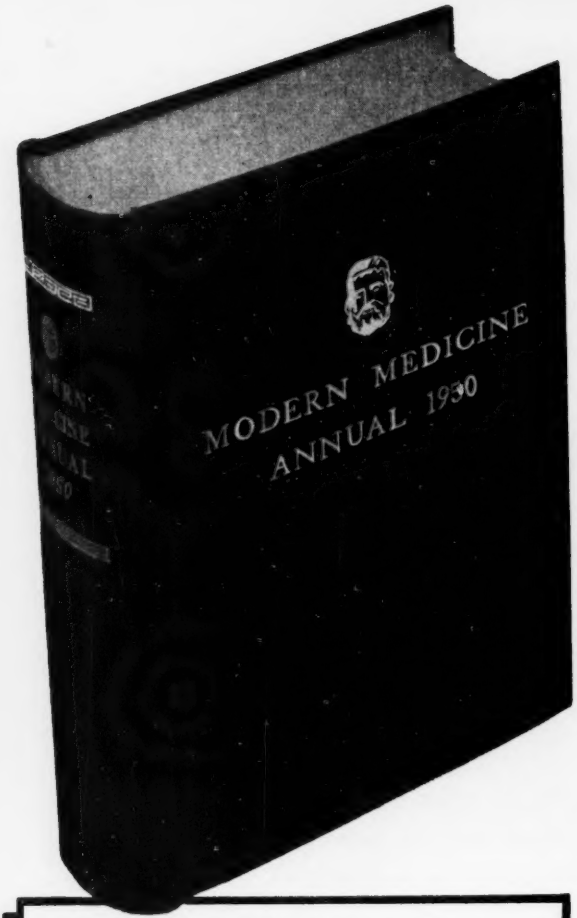

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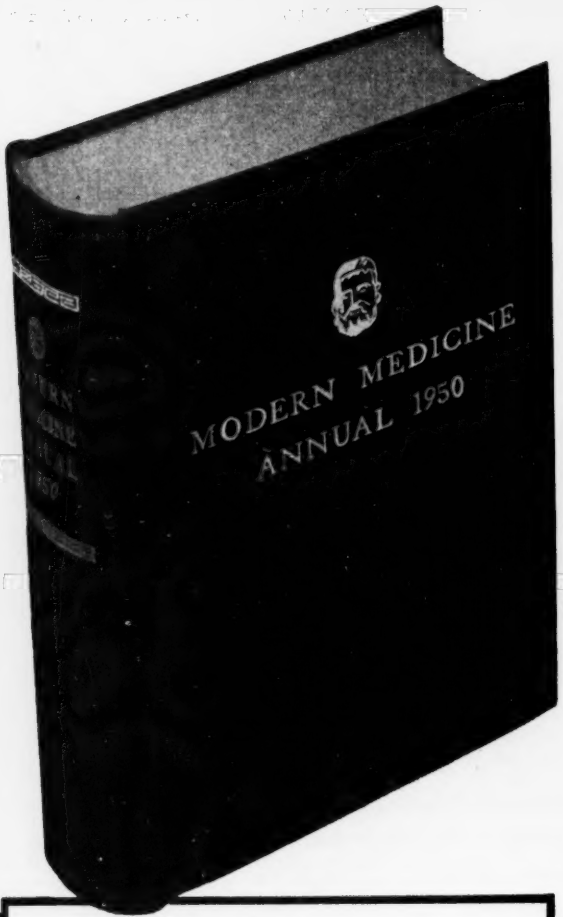

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antihistaminic therapy shortens the duration and decreases the severity of an established cold.[1,2]

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PATIENTS . . . I Have Met

The editors will pay $1 for each story published. No contribution will be returned. Send your experiences to the Patients I Have Met Editor, MODERN MEDICINE, 84 South Tenth St., Minneapolis 3, Minn.

Proportional Representation

A routine history was being taken from a young woman in the gynecology clinic. She was asked if she had noticed anything unusual about her menstrual periods recently.

After some thought, she replied, "No, except that in February my period lasted only two days instead of the ordinary six. I didn't think that unusual because February is a short month."—I.J.M.

An Opportunist

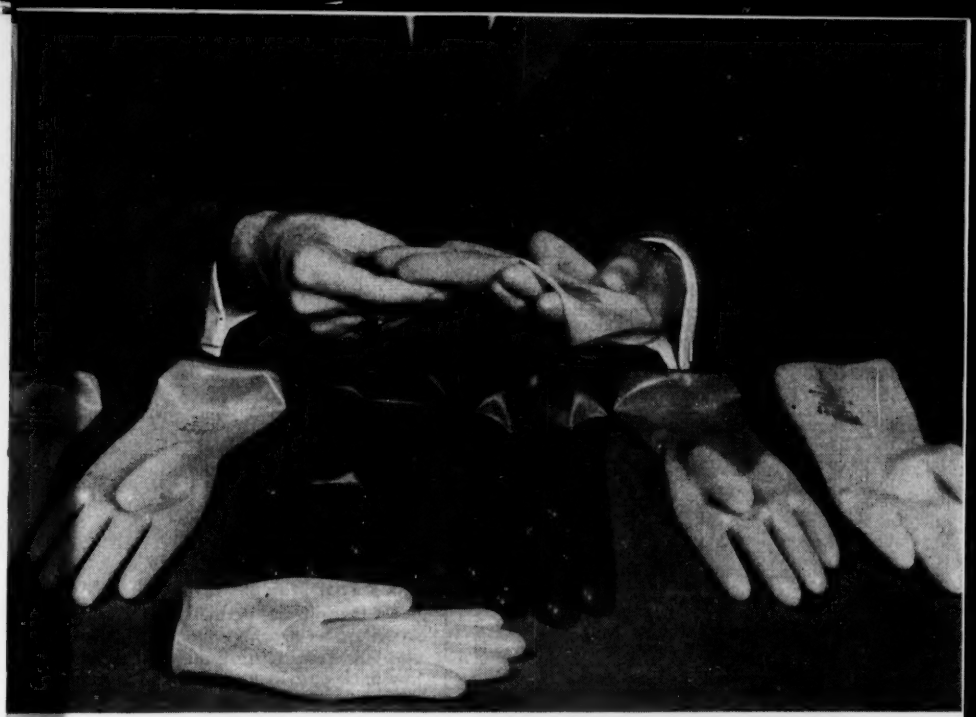
"I'm so discouraged," sighed the pretty nurse, "Everything I do seems to be wrong." With a gleam in his eye the intern asked, "How about a date tonight?"—S.F.W.

A Good Dog

I was caught in a heavy storm in the Ozark foothills and had to impose on the hospitality of one of my patients. At dinner I asked for cream for my coffee.

"Haven't had any milk since our dog died," drawled the hillbilly. Then, much to my relief, he added, "A good dog. He always brought in the cows."—S.S.

"Now exhale."



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"I just had to talk to you alone, doctor, and I didn't want to take up your time at the office."

Can't Fool Him

To the public, penicillin is a cure-all. A patient at my office had some "local in oil" injected in the sacroiliac region for low back pain. He got off the table with the pain completely gone, and asked, "What did you inject, Doc?"

I told him it was a solution we used for local anesthesia.

"Oh, don't kid me," he retorted, "I'll bet you injected penicillin!"—E.A.Z.

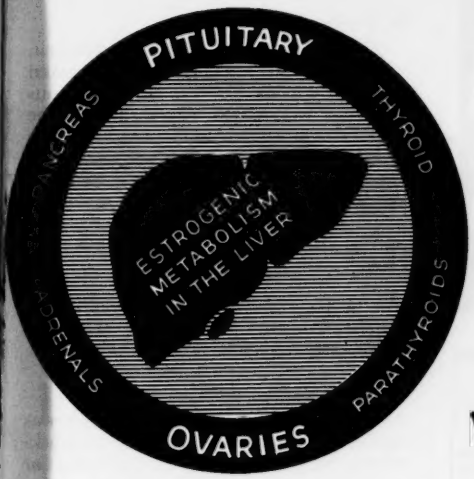
"You know," said the worried patient, "my cousin is in terrible shape. She is pregnant and her doctor tells her she is 4H positive."—L.L.

High Time, Too

I went to Alabama to begin practice. One of my first patients was a young unmarried girl, obviously pregnant. To determine when the baby might be expected I asked her the date of her last menstruation but was answered with a blank look. I asked her several other questions in an effort to elicit some useful information. To each she replied, "I don't know."

Finally, I said in desperation, "Isn't there anything you can tell me that would help fix a date?"

"Oh yes, doctor," she said brightly, holding her hand about a foot above the floor, "I remember the cotton was about this high."—W.G.



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1. Biskind, M. S. and Biskind, G. R.: Endocrinology, 31:109-114 (July) 1942.
2. Ashworth, J. and Sutton, D. C.: Arch Int. Med., 69:15-22 (Jan.) 1942

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Of Course Not

When I was working for a urologist, we treated an old maid for repeated attacks of cystitis. She was very suspicious and kept wondering where she got the infection. She even imagined that she caught it from her clothing. One day in the course of conversation I asked her if she had a boy friend.

She immediately replied, "Well, there isn't anything like that in this business, I'll have you know."—B.S.

"I feel," remarked the recently delivered OB patient, "as though someone had just moved out."—O.S.

Sister Mister.

First day of school, while teacher was occupied, the young children were asked to write their most interesting or exciting experience of the summer vacation. All the students wrote long and volubly except Jimmy, who wrote, "Sister Mister."

When all the students had been seated, the teacher, glancing around the room, noticed Jimmy's contribution. "Jimmy," remarked the teacher, "was 'Sister Mister' the most exciting experience you had during the summer?"

"I should say so," said Jimmy. "Only you didn't read it correctly teacher. It says 'Sister Mister Period."—A.S.

"Hey, Nurse!
The décolleté is cut too low!"

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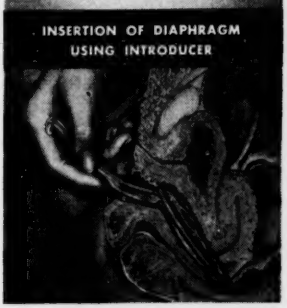

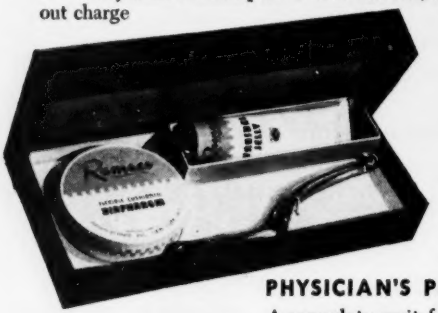

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